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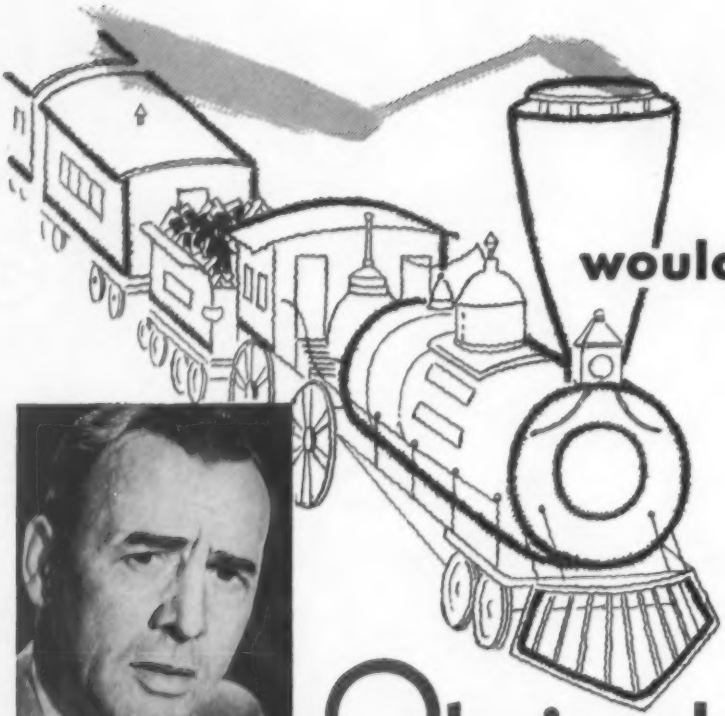
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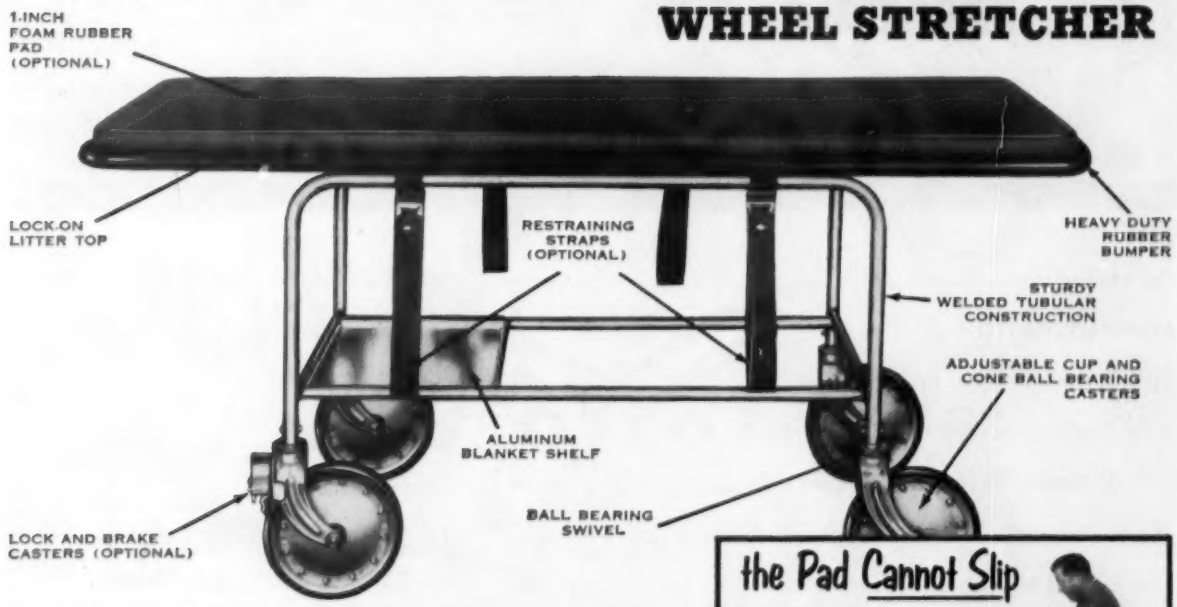


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The Modern Hospital

MAY 1955

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AMONG THE AUTHORS


W. H. Kehlmann

William H. Kehlmann, whose study of the disposable enema unit appears on page 104, is president of Geriatric Associates, Inc., Brooklyn, N.Y. A graduate of Duke University and the Hebrew University of Israel, Mr. Kehlmann studied hospital administration at Columbia University and has been a pioneer in the nursing home field since 1936, having operated nursing homes in Brooklyn, Flushing, New York, and Bronx, N.Y. He was among the first nursing home managers whose proprietary home was registered by the Council on Medical Education and Hospitals of the A.M.A. and accepted as an institutional member of the American Hospital Association.


George E. Linney

George E. Linney was assistant administrator at Georgia Baptist Hospital, Atlanta, when his paper on sprinkler systems (*p.* 87) was presented at the Southeastern Hospital Conference. Since last September he has been administrator of the Americus and Sumter County Hospital, Americus, Ga. Prior to entering the hospital field in 1950, he was associated with the Worthington Pump and Machinery Corporation in Buffalo, N.Y., Washington, D.C., and Atlanta. During World War II, Mr. Linney was an engineering officer in the navy.


Donald E. Brown, M.D.

Dr. Donald E. Brown is pathologist, director of laboratories, and director of the blood bank at the Beverly Hospital, Beverly, Mass. He is also consulting pathologist at the Chelsea Naval Hospital and instructor in pathology at the Harvard Medical School. Dr. Brown is a graduate of Massachusetts State College and Harvard Medical School. He took his internship and residency in pathology at General Hospital, Kansas City, Mo., and then served for two years as pathologist and chief of laboratory service at the Army and Navy General Hospital, Hot Springs, Ark. His article on the national situation in blood banking appears on page 51. **Dr. David N. W. Grant,** whose reply to Dr. Brown's article is on page 52, is director of the national blood program for the American National Red Cross. Dr. Grant was formerly surgeon general of the air forces.


Dean W. Roberts, M.D.

Dr. Dean W. Roberts is director of the national Commission on Chronic Illness. Dr. Roberts received his M.D. degree from Emory University and M.P.H. from Johns Hopkins University. He trained as a pediatrician at the Harriet Lane Home of Johns Hopkins Hospital. He joined the staff of the Maryland State Department of Health in 1943 as chief of the Bureau of Maternal and Child Hygiene. Later he was responsible for the development of the medical care program for the indigent and medically indigent in Maryland and became deputy director of the Commission on Chronic Illness in July of 1952. **Jerry Solon,** co-author with Dr. Roberts of the report on nursing homes beginning on page 67, is health program analyst of the Division of Hospital Facilities, Public Health Service, Washington, D.C., and research assistant of the Commission on Chronic Illness.

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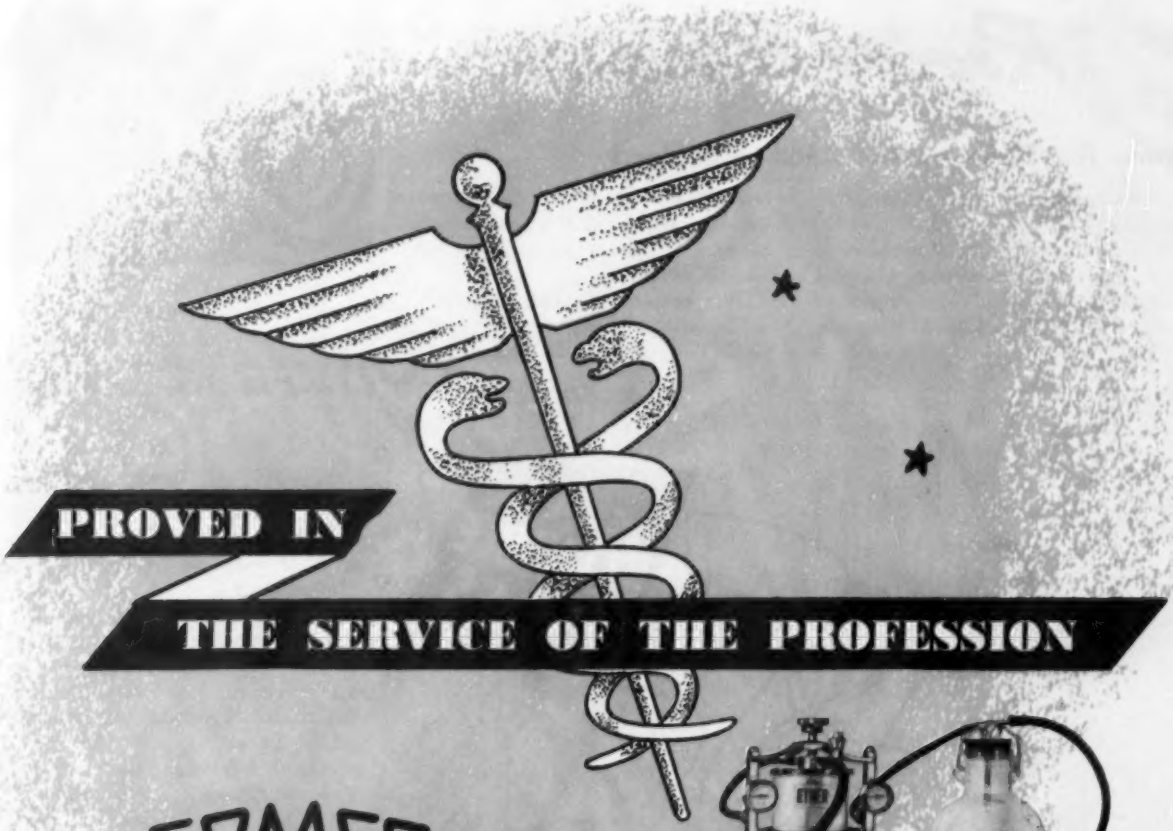
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Roving Reporter

How They Care for the Aged in England

Old people need only a little help to stay on their feet, according to Dr. T. H. Sheldon, director of medicine at the Royal Wolverhampton Hospital, England, and an authority on care of the aged in the United Kingdom. Sometimes outpatient treatment in cases of incontinence or rheumatism can delay the necessity for institutionalization for months, even years, Dr. Sheldon points out.

The provision of suitable spectacles is "far and away the most important single thing that can be done for old people," according to Dr. Sheldon, yet how often, in the United States, elderly patients are given thousands of dollars worth of tests and treatment in the most modern hospital, without anyone noticing their need for glasses!



A ramp replaces the front door of "Half-Way House," one of the homes for semi-invalid or frail ambulant patients who no longer need, or don't yet need, full-time hospital treatment.

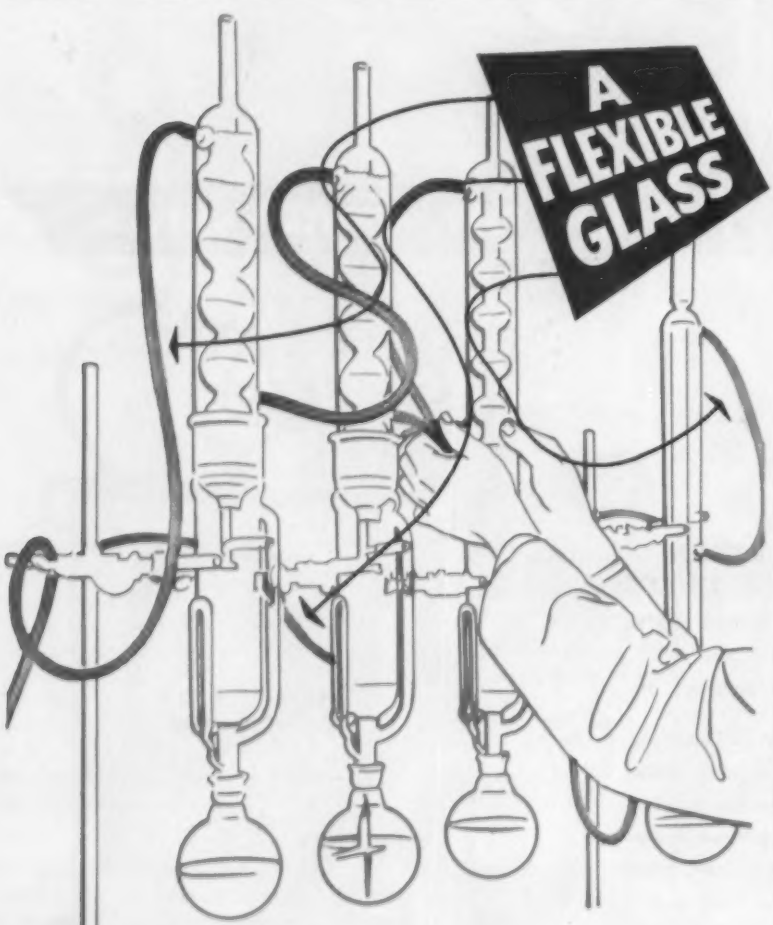
Dr. Sheldon lists as second in importance supplying hearing aids and, third, attention to their feet. He terms "infuriating" the casual acceptance of painful deformities of the feet which cripple an otherwise healthy old man or, more commonly, old woman.

The British today are coming more and more to believe that there has been undue emphasis on the hospital rather than on home care and, as Dr. R. C. Walsh of London puts it, "It is the heartfelt experience of those in everyday contact with geriatric cases that charity often ends in an institution but that humanity begins at home."

The problem which is now foremost in Britain, as elsewhere, is proper correlation between the home and hospital program as it relates to the elderly patient, with the general practitioner the key figure in determining the social and medical needs of his patients.

In the United Kingdom, the program for old people includes social security services to meet financial need; the National Assistance Act under which local authorities provide residential homes; a range of voluntary services of various kinds, and the National Health Service with three main components — hospital service, local health authority service for preventive work and to help those who are sick at home, and a general practitioner service which provides a family doctor for everyone who needs it.

In order to decrease the demands on hospital beds, every precaution is now being taken to see that aged persons remain self-sufficient as long as pos-



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sible. After a study by the council of the British Medical Association in 1946, it was realized that the hospitals were not in a position to provide the necessary number of beds so a program using auxiliary services was set up to provide care for the elderly at home and to delay hospitalization for as long as possible.

Among these services are:

1. The district nurse. She may be reached with a single telephone call; it is not necessary to fill in a form to obtain her help. She may be either a temporary or permanent visitor in the home, and her duties range from injections of various drugs and medications to bathing the oldster at home and many other duties which only a nurse can perform well.

2. Home help. A worker comes to do the housework and shopping for the family and render such services as an ordinary kind lay person can perform.

3. The health visitor, who can be of aid to the physician through talking with the family, and particularly the patient, partly to help them get things off their chests, and also to acquire information which might be useful.

4. The night attendant. This worker is also an important part of the health team, especially in some parts of the country. It is her duty to "mama-sit" in some cases, or more important, she takes over on one or two nights a week to relieve members of the family and give them a good night's sleep.

5. The British Red Cross will lend equipment whenever and wherever it is needed, not only bedpans and commodes, but gadgets to enable the elderly person to sit up in bed or turn over. Red Cross also assists with bars and handles for stairs and lavatories to help patients get around.

6. In 1951, the National Corporation for the Care of Old People opened the first laundry service in Bristol to handle the difficult problem of dealing with soiled sheets, blankets and clothing. Volunteers pick up and deliver the washing and assist with washing and ironing whenever possible.

7. Local authorities have a scheme providing holidays for old people suffering from debility following acute illness. But more important in the "holiday program" is the provision to send someone in to look after the oldster. This service, the British feel, is a real economy as they cite the common occurrence of a spinster daughter taking care of her parents until she herself reaches the breaking point and has to go to the hospital. The parents then must be shunted off to an institution, so that the family may occupy two or three institutional beds.

8. Another project is being pioneered at Oxford—a day hospital for old people. This provides substantially the same facilities as a hospital dayroom, but the patients return to their homes at night. Thus the family is relieved of worry over the oldsters during the day. The companionship offered is also considered a tremendous advantage.

9. Many old people have been admitted to institutions simply because they are homeless. The British Housing Act of 1949 provides hostels for old people who require no special care and attention, but who no longer desire or can afford separate houses of their own. The special housing, now coming into existence, consists of a block of ground floor, centrally heated dwellings, each having a bedroom, living room, kitchen and bathroom. There is a communal recreation room, warden's quarters for the project, and one or two guest rooms. The tenants





This headline from an Eastern newspaper dramatizes the need for safety in Minor as well as Major Surgeries.

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Residents of one of the British residential homes having tea. Dining rooms are equipped with tables seating four persons, and all living areas are made as attractive as possible.

pay rent in the normal way, with the welfare authority providing a grant toward expenses incurred by the housing authority in providing welfare facilities.

10. In addition to the government's efforts, several voluntary agencies in the United Kingdom have been busy trying to provide suitable accommodations for the elderly, either by building new buildings or by acquiring existing properties and converting them into bed-sitting rooms with communal kitchens and bathrooms. One such scheme, for elderly ladies, is operated jointly by voluntary and government effort at rates from $1 to $2 a week, depending upon the size of the room. Light, hot water, cooking fuel, and outside window cleaning are furnished, so that a large number of elderly people can live better and happier than they could in the kind of home they would be able to provide for themselves or in an institution.

11. For those old people who can get out and about, a large number of clubs have been founded which are open weekly, or even daily, where members are provided with entertainment, recreation and occupation and light refreshments. These clubs give the oldsters companionship and something to look forward to.



Guests in residential homes may take their own possessions and furniture with them when they move in, which makes their new lives much happier.

When it becomes impossible to keep the older citizens in some kind of home of their own, private or community, the next step is the residential service, provided by the welfare authority for those, including the aged and the infirm, who need care and attention which they cannot get otherwise. However, these are not classified as sick, whose treatment then becomes the responsibility of the hospital authority.

The Minister of Health broadly defines the infirm as "persons who are normally able to get up and who could attend meals either in the dining room or a near-by dayroom." (Also included are those persons who need some help in dressing, toilet or in moving from room to room and who are inclined to have to spend an occasional few days in bed.)

The definition of *sick* is "patients requiring continued medical treatment or supervision and nursing care." (This includes the physically and mentally ill, and old people who are not suffering from any particular disease but who are confined to their beds because of extreme weakness.)

TWO TYPES OF HOMES

Residential homes for the aged and infirm are usually of two main types: small homes accommodating between 20 and 40 persons, and larger establishments, many of which were formerly almshouses and poorhouses. Because of the nature of the two institutions, the first usually house the less serious cases while the large institutions seem to be better suited for the more infirm and for persons who require extra care, including the mentally infirm, the subnormal, and the antisocial. The purpose of the home (residential service) is to give the residents the care and attention they need to keep them as healthy, safe and happy as possible, and to maintain them in the greatest measure of independence of which they are capable. The service meets all of their reasonable needs while the little luxuries like sweets and tobacco are supplied if they cannot afford to buy them. The places are generously supplied with books, newspapers, magazines, opportunities for religious worship, piano, radio and nowadays, in most of the residences, even television. Dining rooms are equipped with small tables seating four persons while lounges and bedrooms are attractive

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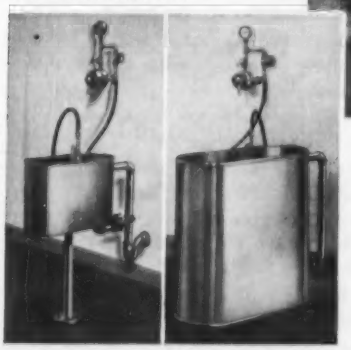
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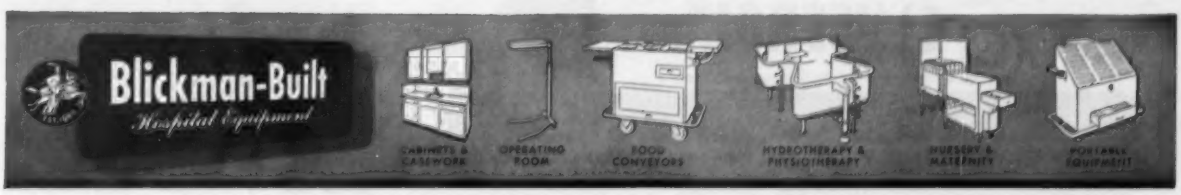
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You are welcome to our exhibit at the Catholic Hospital Association Convention, Kiel Auditorium, St. Louis, Mo., Booths No. 200-204, May 16-19, and to the Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City, N.J., Booths No. 314-316, May 25-27.

and comfortable. Wherever possible, there are extra handrails for stairs, freestanding baths, call-bell systems, and many other conveniences, including ramps.

The rules are few, and the rates vary with the income, in no case less than $3.50 a week. Patients choose their own clothes and may bring in their own possessions within reason. Recreation may take the form of occupational therapy in handicrafts, films, concerts and occasional outings.

Every resident is entitled to his own doctor, and in some cases, a general practitioner in the district makes regular rounds. There is a medical staff to supervise the hygiene of the home, and to rule on heating, ventilation, sanitation and nutrition.

When they have reached the point where they need even more care, a consultant physician of a geriatric unit visits the old people and advises whether or not they can continue to live in the residence and receive outpatient care, or whether they need to be hospitalized.

The newest phase in the problem of institutions for the aged is the intermediate home, or "half-way house" for semi-invalid or the frail ambulant, who either no longer needs or doesn't yet need full-time hospital care and treatment.

These institutions were first provided by the King Edward's Hospital Fund, and later by the National Corporation for the Care of Old People, which was established in 1947 by the Nuffield Foundation. These institutions "between a welfare home and the hospital" are equipped to admit and keep any aged person indefinitely if he does not require hospital treatment. Admission to the "half-way house" is only through a well established geriatrics unit of a hospital, which guarantees to receive back the patient if he needs more nursing and medical care than the "half-way house" can provide.

In the hospitals themselves, geriatrics units are more common than in comparable hospitals in the United States and probably no other country is concentrating more of its research on the whole problem of aging.—BARBARA CALLAHAN.



THROUGH USING ONLY ONE CASE OF CLYSEROL!

By extension, it's easy to see that this safe, mild but promptly effective formula can save you MANY DAYS OF PERSONNEL TIME A YEAR. And, by using Clyserol, you've made a hard task easy for both the patient and the nurse. Next time you order, remember that *the time you save more than pays for*



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5-MINUTE ENEMA SOLUTION IN A DISPOSABLE PLASTIC CONTAINER

CLYSEROL LABORATORIES, INC. 1533 West Reno, Oklahoma City, Okla.

The Young Visitors

Juvenile visitors are persona non grata in most hospitals, but is that taking the long view? Some hospitals in western Washington are looking ahead to tomorrow's adults and have arranged tours at which children are welcome.

When Vancouver Memorial Hospital observed its 25th anniversary last year, Manager Paul S. Bliss crossed his fingers and invited children to accompany their parents at an open house.

"We didn't know what we might be letting ourselves in for," he told the editor of *Washington Hospitals* afterward, "but as it turned out the children were among the most interested visitors. We feel we made future friends for hospitals."

Providence Hospital in Everett also lets children come in small groups, including Campfire Girls and their junior organization, the Bluebirds. The theory is that, since these children cannot visit their parents or brothers and sisters when patients, they may conjure up distorted ideas about what goes on in a hospital. A small conducted tour makes them intelligent young citizens about one of the chief services their community provides the public.

In America,

the word for Gentle Absorbency is

FORT HOWARD
TOILET TISSUES!





Speak up, Sergei . . . it's an open secret, anyway! Fort Howard Tissue Products *are* surpassingly soft, gentle and absorbent — but best of all, so economical! For example, the difference between an ordinary tissue service and Fort Howard's finest is just 7c per hundred users . . . an insignificant sum compared with the extra quality and comfort it buys!

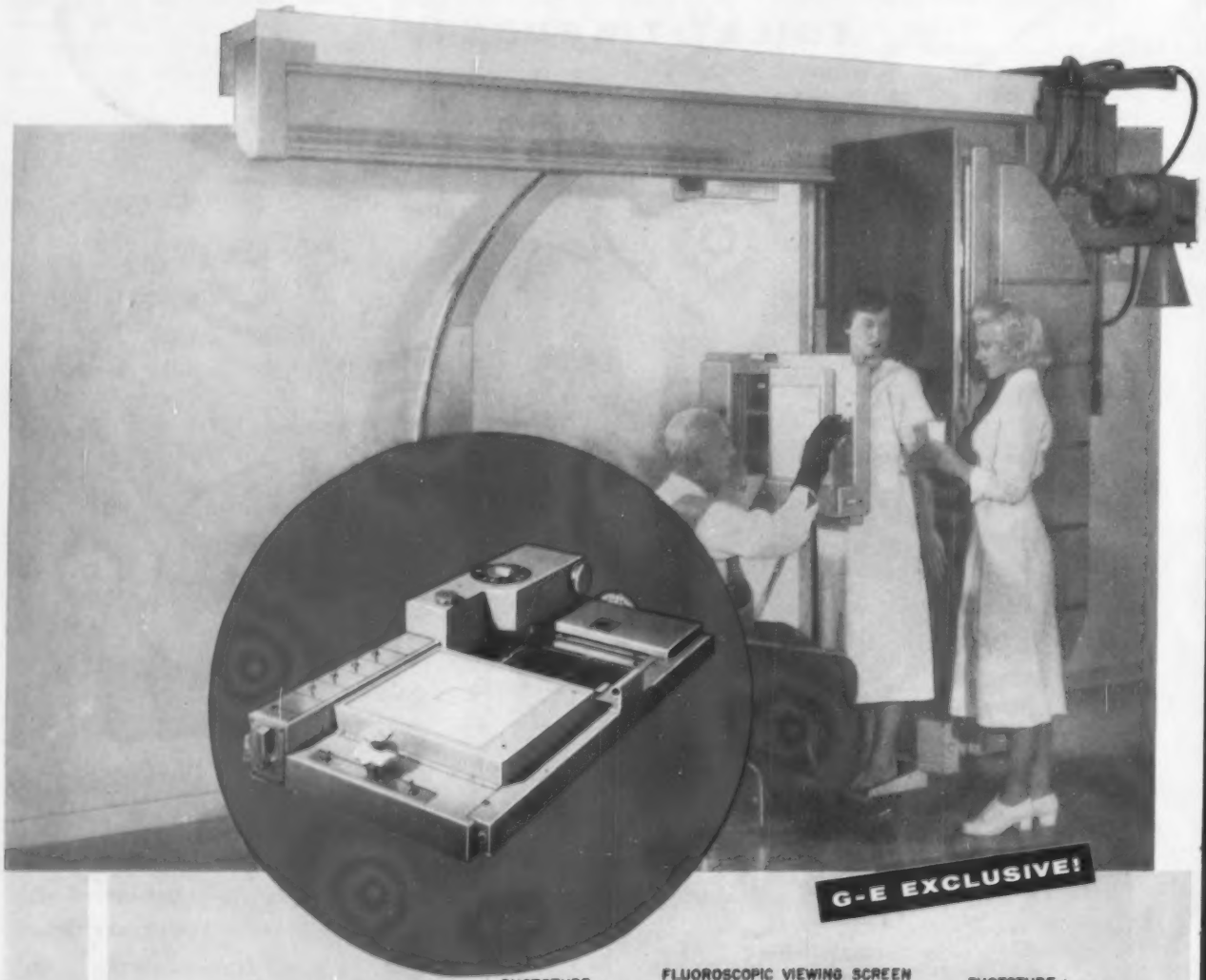
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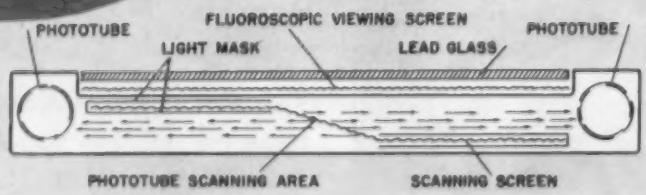
✓ this consistency and versatility in spot-film technics



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CONSISTENT SPOT-FILM DENSITY

Only the IMPERIAL assures consistent density of your spot-films, since its phototiming unit is sealed—housed phototube cells are not affected by varying room illumination. Scanning area of sealed-in screen is always directly above area you are spot-filming.



you'll want the IMPERIAL

this comfort and ease in fluoroscopic screening

If you find that all too often your morning's fluoroscopy extends into the afternoon — without a "break" — then here are just the right fluoroscopic facilities that will lighten your heavy work schedule.

Thanks to the IMPERIAL'S ring-counterbalanced spot-film unit, you move *180 pounds less* during longitudinal screening, *60 pounds less* during vertical.

While fluoroscoping during table angulation your screen-eye relationship is almost constant — the screen neither approaches you during vertical angulation, nor recedes during Trendelenburg.

You control the dual table-angulating speed *uninterruptedly* through 180°. Or *you* choose automatic stop-over at horizontal.

With choice of two vertical table positions, you can operate the spot-film controls with either left or right hand.

Then, when you are ready, IMPERIAL'S split-second cassette traversal lets you make spot-films — *instantly*.

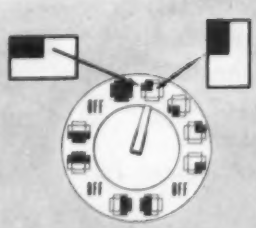
Yes, in *all* phases of fluoroscopy and radiography, you'll find IMPERIAL opens new vistas of ease, speed, versatility and accuracy. Get the facts from your G-E x-ray representative, or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin. Ask for Pub. H51.

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Like all G-E x-ray apparatus, IMPERIAL can be yours — without initial capital investment—on the Maxiservice® rental plan.

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GENERAL ELECTRIC



18 EXPOSURE AREAS

Convenient selector knob offers quick choice of 18 spot-film exposure areas — plus automatic sequencing.

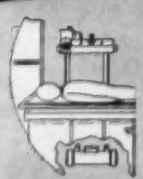
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One glove, not a pair, no sorting necessary

Short wrists—quick, easy donning for dressings, treatments

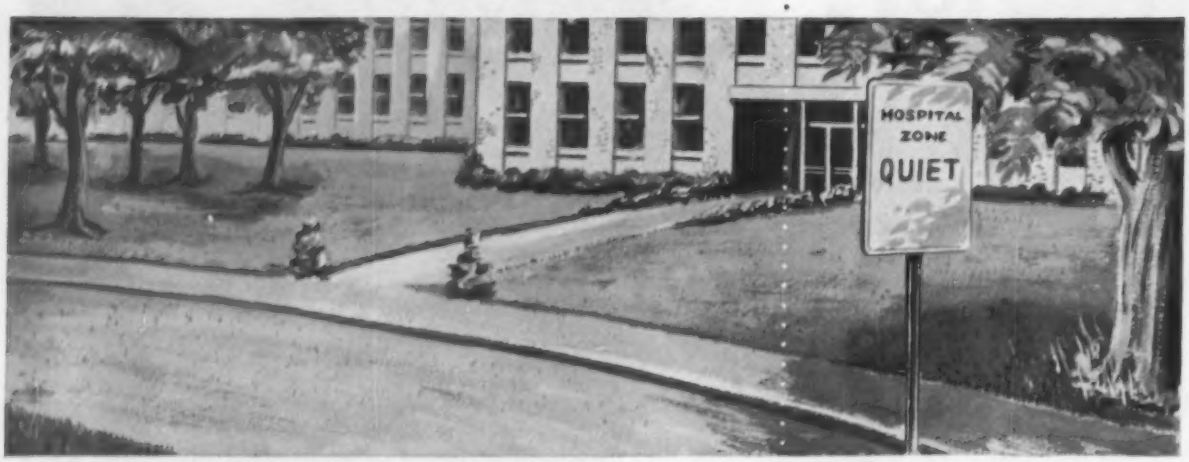
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In Appreciation



The great advances in the fields of hospital service and management have ranked among the most heartening developments of recent years. With modern hospital and medical care, Americans today enjoy better health than ever before in history. Hospitals are truly the health centers of their communities.

National Hospital Week makes all of us realize that our hospitals represent a form of security for healthy people as well as for those who are injured or ill. National Hospital Week affords the nation the opportunity to show its appreciation for the vital services performed by the men and women who make up the hospital team.

We in the health insurance business have enjoyed first hand acquaintance with the people who man the American hospitals, and we are proud to work with them. National Hospital Week has a great deal of significance for us and we honor the hospitals with real feeling.

On behalf of our policyholders and ourselves, it is a pleasure to salute all you members of the hospital team during Your Week for your fine tradition of public service!

The HEALTH INSURANCE COUNCIL

THE HEALTH INSURANCE COUNCIL IS AN ORGANIZATION OF INSURANCE COMPANIES WRITING HEALTH INSURANCE. THE COUNCIL EMBRACES NINE INSURANCE ASSOCIATIONS IN ITS MEMBERSHIP. THE COUNCIL SERVES THE HOSPITAL AND MEDICAL FIELDS AS A CENTRAL SOURCE FOR TECHNICAL AND PRACTICAL ASSISTANCE IN CONNECTION WITH THE DEVELOPMENT AND USE OF ACCIDENT AND HEALTH INSURANCE.

Effective in Every Type of Vaginitis

AVC Improved cream

Possesses all the advantages of the ideal vaginal anti-infective

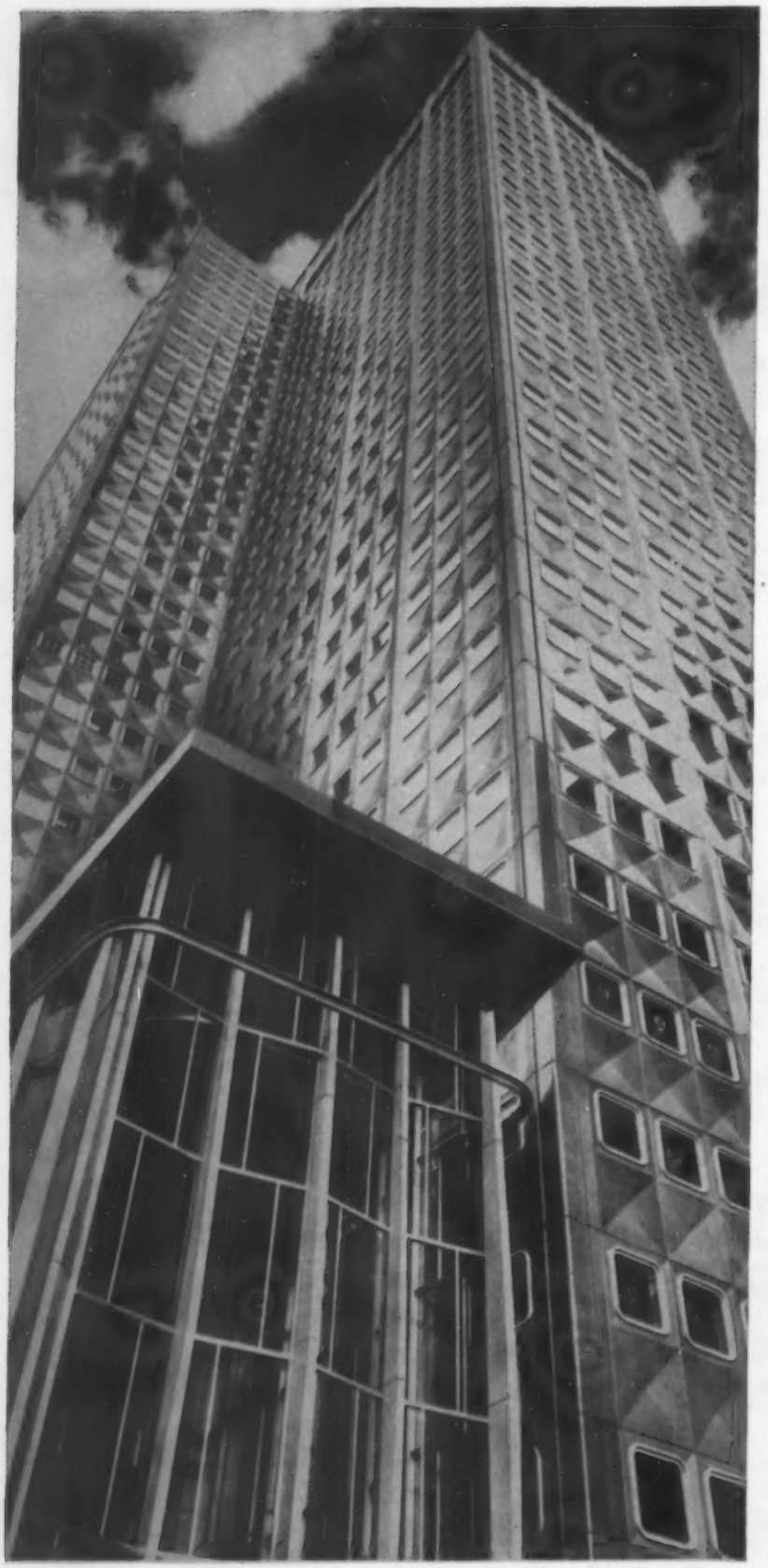
	AVC (Cream)	Product A (Liquid or Jelly)	Product B (Powder or Insert)	Product C (Jelly)
Efficiency	Provides broad-spectrum attack against: **bacteria, monilia, and trichomonads.**	Effective against **trichomonads only.**	Not effective against monilia.	Effective against **monilia only.**
Convenience	Convenient plastic applicator.	Requires 2 dosage forms: liquid and jelly.	Requires office treatment and home administration. Special douches recommended.	Disposable applicator. Therapy is expensive.
Duration of Therapy	1 month, or 1 menstrual cycle.	Through 2 menstrual periods.	Through 3 menstrual periods, then during menses only for 2 additional months.	20 days—therapy is short **provided vaginitis is due to monilia only.**
Stain	No	No	No	Yes

AVC Improved contains:

Sulfanilamide **15%**
9-Aminoacridine HCl **0.2%**
Allantoin **0.2%**

NATIONAL

THE NATIONAL DRUG COMPANY
Philadelphia 44, Pa.



who

Alcoa Building, (left), Pittsburgh, Pennsylvania
Architects: Harrison & Abramovitz
Associate Architects: Mitchell & Ritchey
Altenhof & Bown
General Contractor: George A. Fuller Company
Date of Adlake Window order: January 25, 1951

North Central Home Office
Prudential Insurance Company of America,
Minneapolis, Minnesota
Architects and Engineers: Magney, Tusler & Setter
General Contractor: C. F. Haglin & Son's Co.
Date of Adlake Window order: October 19, 1953

Prudential Insurance Company of America,
Chicago, Illinois
Architects: Naess & Murphy
General Contractor: George A. Fuller Company
Date of Adlake Window order: November 12, 1953

Shelby County Hospital, Shelbyville, Kentucky
Architects: Nevin & Morgan
General Contractor: Otho Tapp
Date of Adlake Window order: June 24, 1952

City County Building, Detroit, Michigan
Architects: Harley, Ellington & Day
General Contractor: Bryant & Detwiler
Date of Adlake Window order: January 12, 1953

Freeport Motor Casualty Company, Freeport, Ill.
Engineers and Contractors: The Austin Company
Date of Adlake Window order: June 2, 1952

East Unit, Baptist Memorial Hospital,
Memphis, Tennessee
Architects: Office of Walk C. Jones, Jr.
Consulting Architects: Samuel Hannaford & Sons
General Contractor: Harmon Construction Company
Date of Adlake Window order: June 23, 1953

Rockford Memorial Hospital, (right), Rockford, Ill.
Architects: Hubbard & Hyland
Perkins & Will
General Contractor: Security Building Company
Date of Adlake Window order: December 26, 1951

originated aluminum reversible windows?

Anyone can claim to—but **ADLAKE** can show installations sold as early as these!

There's a lot of talk these days about companies "developing" aluminum reversible windows—and we're rather flattered. For we like to think the sudden rash of "new" windows proves that a lot of people looked at the Adlake Aluminum Reversible Windows (that we sold 'way back in January, 1951) and liked what they saw.

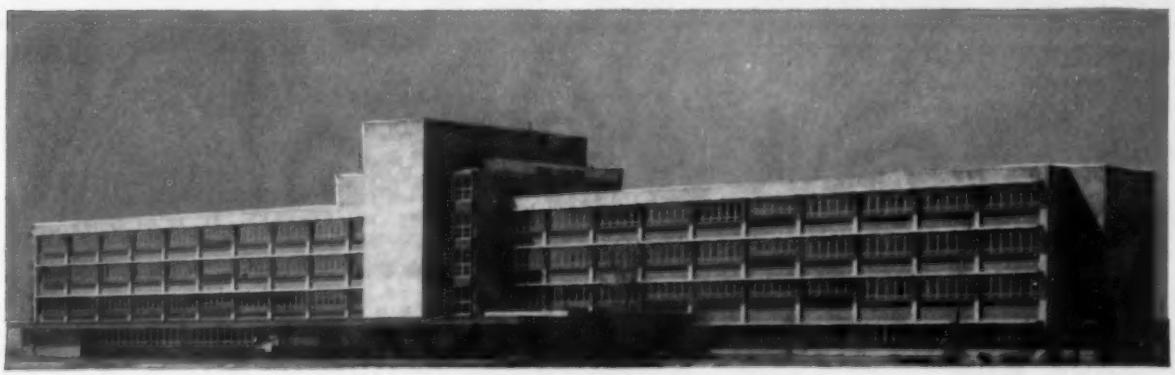
Take a look yourself—at the outstanding buildings listed here. They're all equipped with Adlake Aluminum Reversible Windows. (And just to keep the records all straight, we've put in the dates when the orders were placed with Adlake for the windows.)

As with all Adlake products, these windows had to undergo extensive testing before they were offered for sale, so the windows were designed and *developed* several years before the first order was placed. We believe Adlake was first with aluminum reversible windows, and until we see some installations that were sold earlier, we'll keep right on thinking so!

THE Adams & Westlake COMPANY

Established 1857 • ELKHART, INDIANA
New York • Chicago

Adlake 98th year of serving the transportation and building industries





DOES A FLOOR MOP REACH THE WOUND IN A MODERN HOSPITAL?

A recent article in a national magazine says it does.

Floor care seldom comes within the surgeon's jurisdiction, yet an article in a national magazine says that a wound may be reached by the mop more frequently than by the surgical instruments.

A startling and dramatic statement! The writer, no doubt, refers to the bacteria-laden dust which is scuffed from the floor in the operating suite and air-borne to the wound. It can be prevented.

Every surgeon knows and guards against the dangers of wound infection during and immediately after the operation. Yet his efforts towards protection may unwittingly be of little avail if aseptic conditions aren't properly maintained in every respect within the operating suite.

Korex Germicidal Cleanser with a phenol coefficient of 2 helps to promote good asepsis from floor to ceiling. It takes much of the threat out of the mop. When Korex, a liquid cleaner, is used in the scrub water for cleaning floors, walls, fixtures—anything that cannot be autoclaved after one operation and before the next—it kills most harmful bacteria and reduces the total count to safe tolerances—well within the limits of the body's natural defenses in most cases.

Korex Germicidal Floor Cleaner is not a cure-all, but it is a step toward better asepsis and safer operations. Write us at Huntington, Indiana, today for prices and complete information. If you would like a sample for testing, please indicate that in your letter.

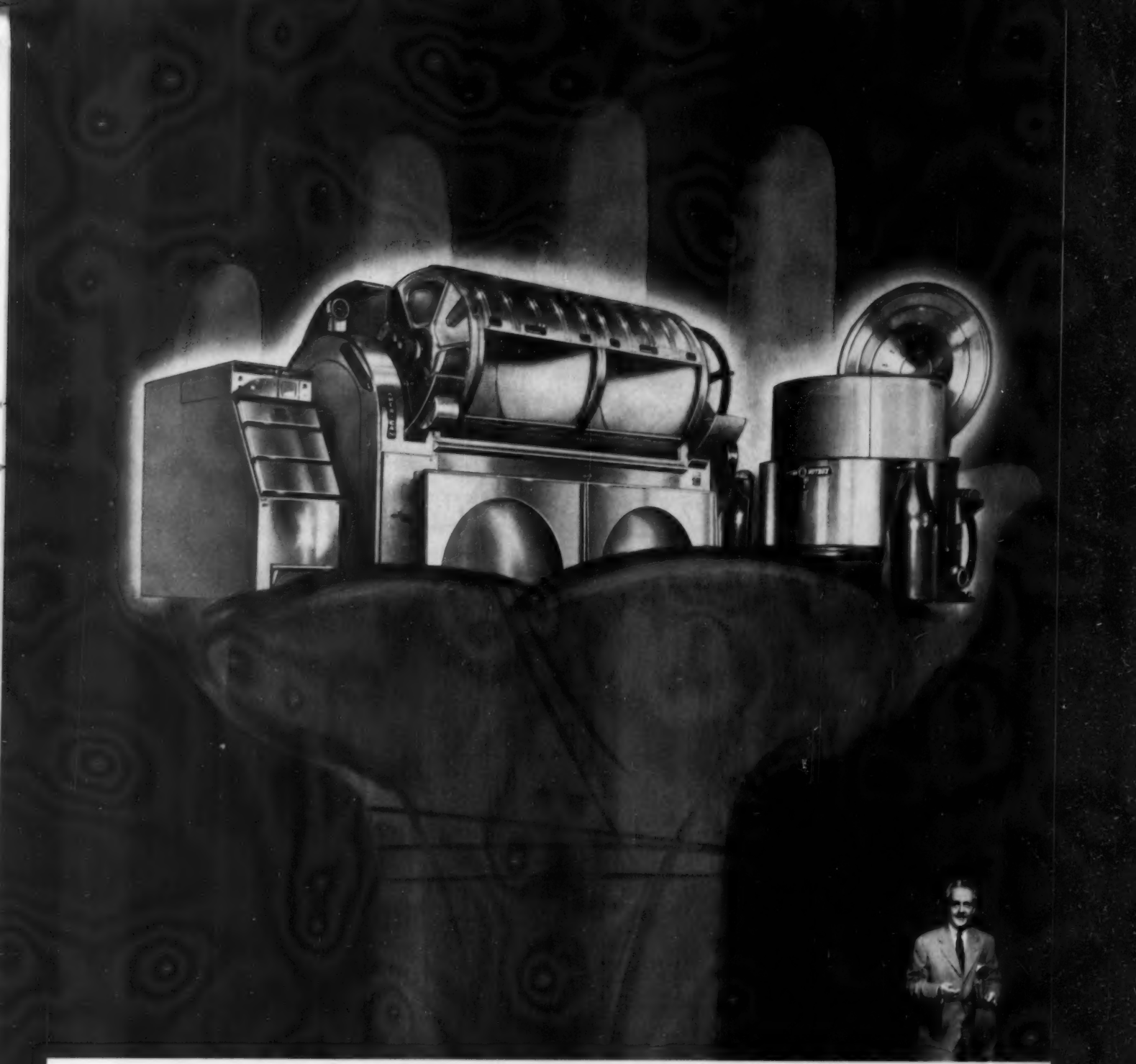
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Only "full-automatic" cuts soaring labor costs!

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You can depend on your American Representative's advice in your selection of equipment from the complete American Line. Backed by our 87 years experience in planning and equipping laundries, he can help solve your production problems. Ask for his specialized assistance anytime . . . no obligation.

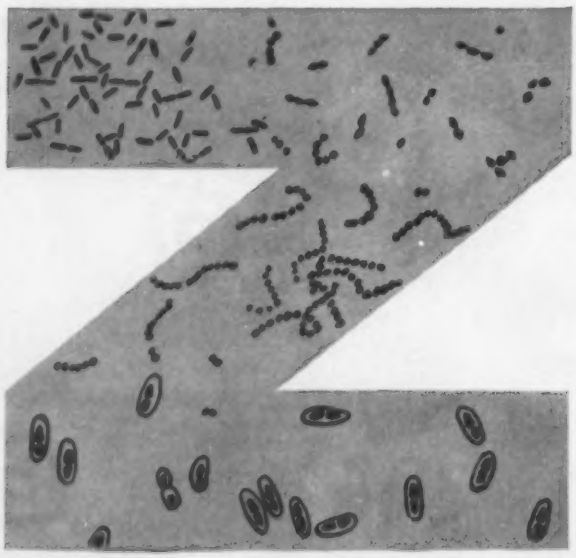
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with quick acting economical **Zephiran®** CHLORIDE

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Naturally curved fingers insure freedom from binding, strain and operating fatigue.

Made from pure, natural latex with quality rigidly controlled throughout manufacture to provide greater tensile strength and longer sterilization life.

WILSON

LATEX SURGEONS' GLOVES

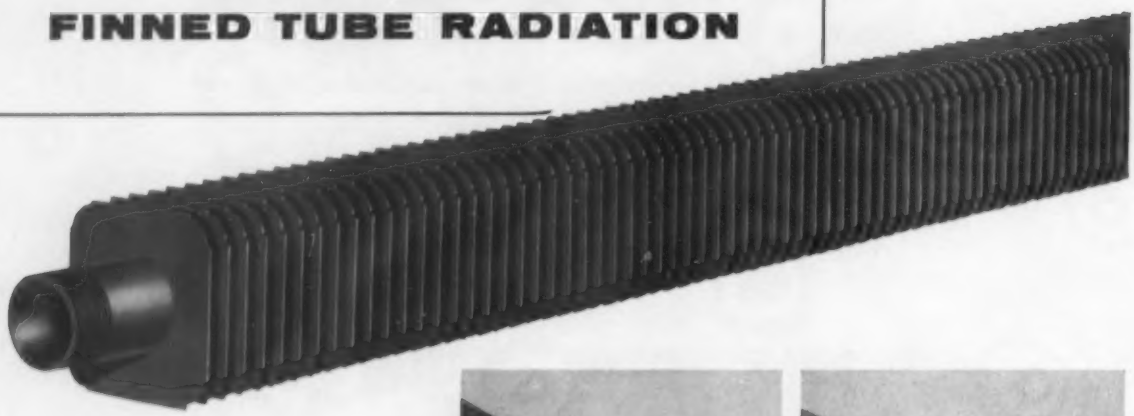


THE WILSON RUBBER COMPANY B·D

A DIVISION OF BECTON, DICKINSON AND COMPANY • CANTON, OHIO

TEMTRIM

FINNED TUBE RADIATION



provides maximum heat at minimum cost

Temtrim Finned Tube Radiation is ideally suited for installation in a variety of buildings, including schools, hospitals, factories, churches, and similar structures. It affords high heat output, is economical to install and to operate and takes up very little space along the wall.

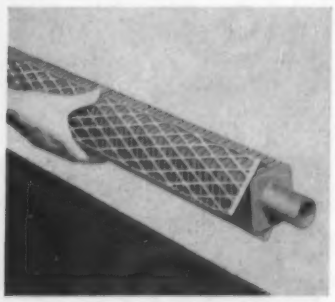
Temtrim Finned Tube Radiation, usually installed along the cold outer walls, is used with forced hot water or two-pipe steam systems. The steel fins, securely bonded to the heat-carrying tube, greatly increase the heat transfer surface, and make it one of the most efficient heating units yet developed.

Because of its adaptability to the heating requirements of a variety of buildings and its ease of installation, Temtrim Finned Tube Radiation is used for modernization as well as new work. Because Temtrim takes up so little space and supplies such an even heat flow, every foot of floor space can be put to productive use.

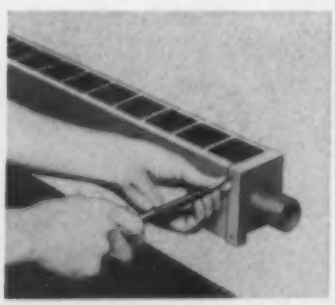
For more information, see your American-Standard Sales Office or write to Plumbing and Heating Division of American Radiator & Standard Sanitary Corporation, P. O. Box 1226, Pittsburgh 30, Pa.



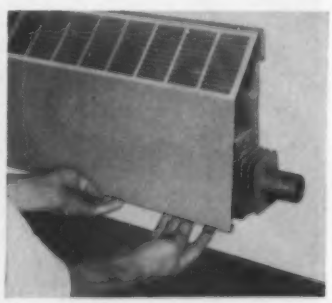
Where appearance is not of primary importance, Temtrim Finned Tube Radiation can simply be installed without a cover. However, there are three attractive covers available . . .



The Expanded Metal Grille is installed by slipping it directly over the heating element. It has no sharp edges to catch clothing or cut fingers.



The Flat Top Cover is a one-piece unit featuring a solid front and louvered top with louvers slotted at 30-degree angle for better air flow.



The Sloping Top Enclosure, of smart, modern design, discourages the use of the unit as a seat or shelf . . . provides an attractive installation.

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Clarke vacuum cleaners pick up wet or dry – provide facilities for fast, thorough cleaning from basement to attic.

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FARWELL & COMPANY
Dallas, Texas





One of the most important features of this 1000 bed hospital valued highly by patients and staff alike is: It is completely air conditioned throughout and Powers controlled.

Left: View of Entrance Lobby with Portraits of the Founder, John Sealy, Sr., and John Sealy, Jr.



Below: Post Operative Recovery Dept. has nine beds.



Below: Research Laboratory



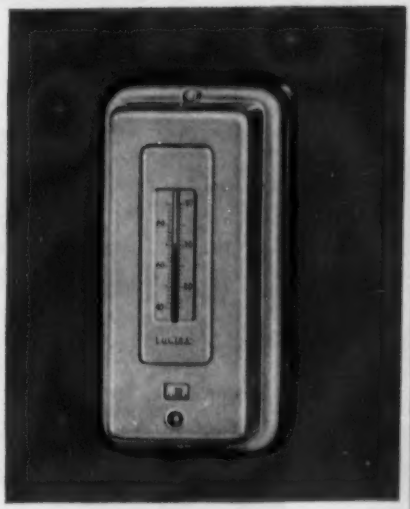
Below: Surrounding Corridors for Central Operating Rooms



Behind the scenes in this modern hospital

POWERS Automatic TEMPERATURE and HUMIDITY Control

is contributing to the quality of patient care



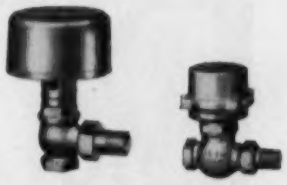
Radial Type Surgical Department shown in drawing below, is one of the many new concepts incorporated in this center for healing.

The radial type plan is based on a theory of centralization permitting a compact layout to increase nurses' efficiency by reducing their steps. Powers automatic control of the working climate further increases staff efficiency and contributes to the health and comfort of the patients.

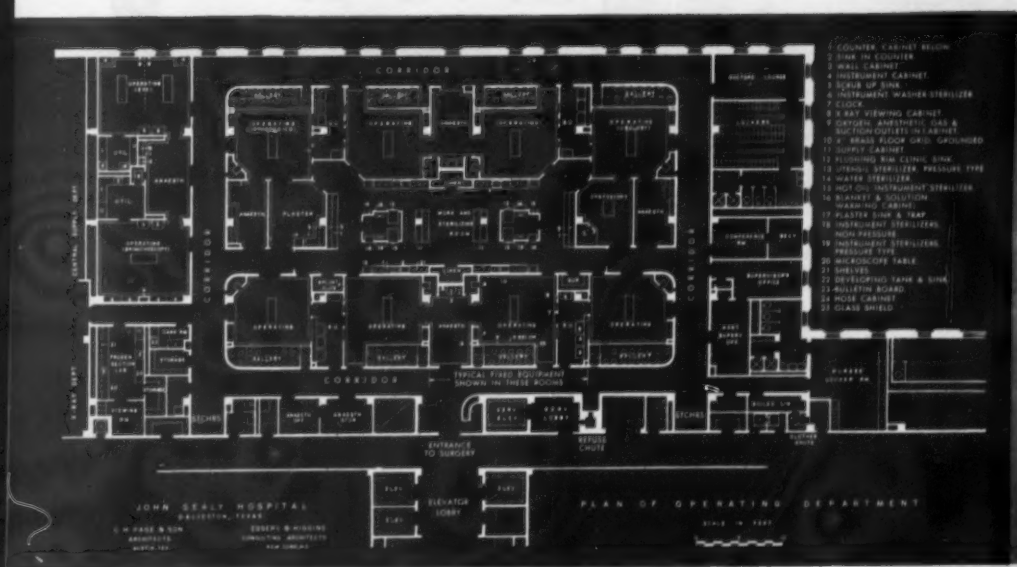
Being completely air conditioned the building requires 1250 tons of refrigeration.

Almost 700 Powers Gradual Acting Thermostats here control 125 Damper operators and 930 PACKLESS Valves on air conditioning units and convectors. Other controls consist of 7 Series 100 Master-Submaster Controller Recorders, Pressure Indicating Controllers and 70 Powers FLOWRITE Diaphragm Valves.

(c14)

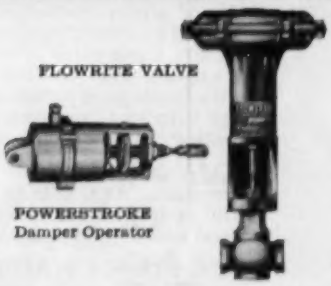


Powers PACKLESS Control Valves – one of the many superior features of a Powers control system. They eliminate packing maintenance and leakage of water or steam and give smooth accurate control.





Consult Powers when you want thermostatic control for any type of new or existing building. No other firm makes as big a variety of temperature controls for heating and air conditioning systems, shower baths, hydrotherapy, X-Ray film developing, water heaters, fuel oil preheaters and other hospital applications.
For further information call your nearest Powers office or write us direct.



FLOWRITE VALVE

POWERSTROKE
Damper Operator

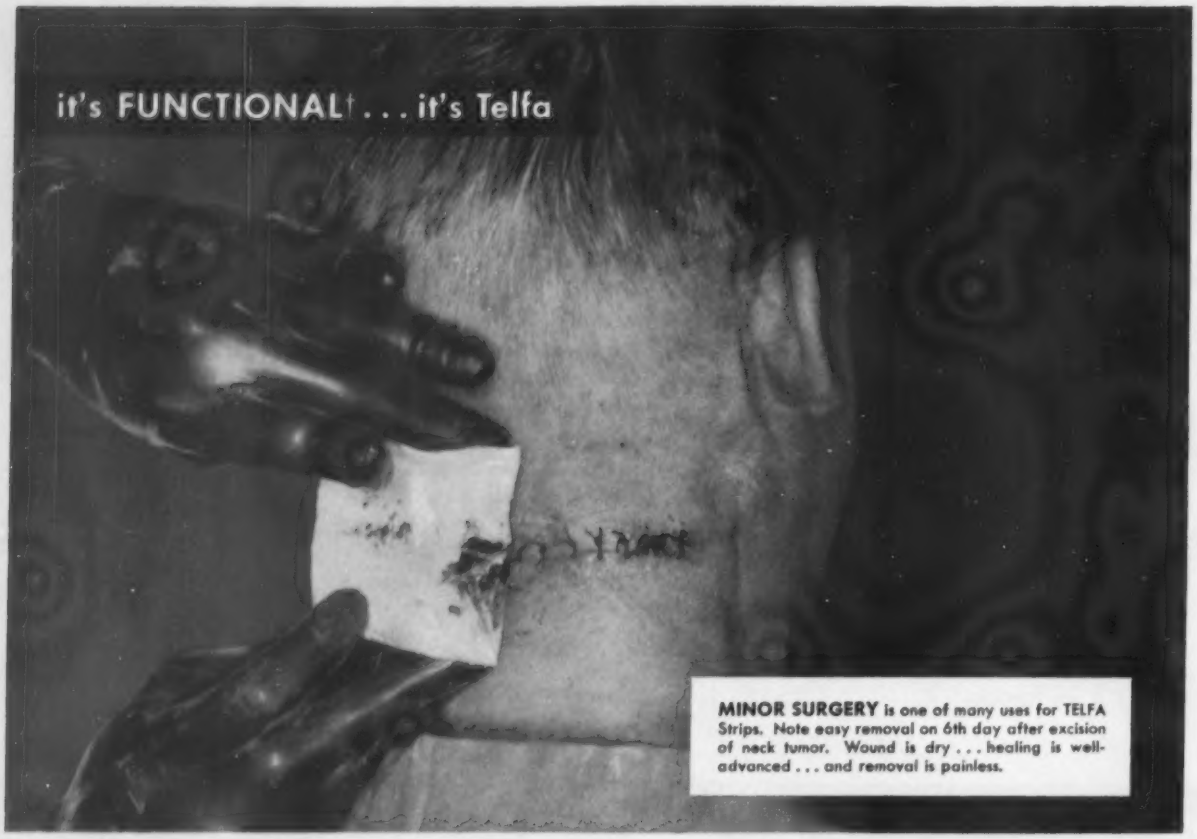
THE POWERS REGULATOR COMPANY

SKOKIE, ILLINOIS | *Offices in chief cities in U.S.A., Canada and Mexico*

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POWERS CONTROL

More than 60 years of Automatic Temperature and Humidity Control



MINOR SURGERY is one of many uses for TELFA Strips. Note easy removal on 6th day after excision of neck tumor. Wound is dry . . . healing is well-advanced . . . and removal is painless.

New TELFA dressing is first in history that

promotes primary wound healing

All-new, all-purpose TELFA is first completely non-adherent dressing that keeps wounds dry

Non-adherence *plus* absorbency . . . that is the achievement of TELFA Strips, revolutionary new *Curity* dressing. It means, for the first time, an all-purpose dressing that keeps wounds dry without sticking—that encourages natural, uninterrupted healing.

ENTIRELY NEW PRINCIPLE—TELFA Strips consist of a non-wettable, perforated plastic film bonded to *Webril*® backing of 100% pure absorbent cotton. Used alone or with overlying dressings, it is applied with *film side* next to wound, and held with bandage or adhesive. Perforations pass drainage into pad, prevent reverse flow. And regenerating tissue can't grow into dressing.

TELFA COSTS LESS per patient than conventional dressings. Available in standard 2½" x 4" and 3" x 8" strips, in hospital cases; and in 2" x 3" sterilized envelopes for doctors.

NEW SIZE FOR PLASTIC SURGERY AND BURNS: *new 8" x 10" size is especially suitable for dressing donor and recipient skin-graft sites, and for extensive burns.*

Count on Curity for †DRESSINGS THAT WORK

Curity dressings are *functional* dressings—"built from the wound up" to promote faster healing. This is the *Curity* approach to better hospital dressings for better patient care. And the greater efficiency of *Curity* dressings means *lower cost per patient*—the true measure of dressings economy.

Curity

TELFA*

NON-ADHERENT STRIPS

BAUER & BLACK

Division of The Kendall Company
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When the patient must be fed by vein



LEVUGEN

(FRUCTOSE, MEAD)

is the sugar best utilized in stress

Advantages of Levugen

- is metabolized when utilization of dextrose is impaired
- causes less disturbance of fluid balance
- causes less diuresis and urinary spillage
- causes less fluctuation of blood sugar
- converts into glycogen without insulin

Levugen® is pure fructose, a physiologic sugar. And unlike dextrose or invert sugar (half dextrose and half fructose), Levugen is utilized by patients in illness or in stress approximately as in normal individuals. For varying needs, nine Levugen solutions are available.

New Special Electrolyte Solutions

For moderate or severe electrolyte loss
Levugen 5% with Electrolyte No. 75

For the replacement of gastric electrolytes
Levugen 10% with Electrolyte No. 150

For general purpose or duodenal replacement
Levugen 5% with Electrolyte No. 158

For calories and maintenance electrolytes
Levugen 10% with Electrolyte No. 45

For the rationale of specific electrolyte solutions see . . .

Cooke, R. E., and Crowley, L. G.: New Eng. J. Med. 246: 637 (April 24) 1952.

Fox, C. L., et al.: Electrolyte Solution Approximating Plasma Concentrations, J.A.M.A. 148: 827 (March 8) 1952.

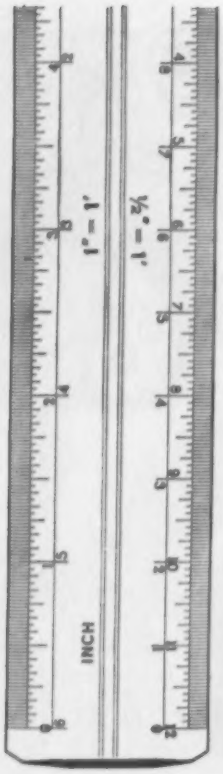
Talbot, N. B.; Crawford, J. D., and Butler, A. M.: New Eng. J. Med. 248: 1100 (June 25) 1953.

The complete Mead I.V. line, including Levugen and Amigen solutions, is readily available to your hospital from a conveniently located Mead warehouse.

Write for reprints, "A-B-C's of Fluid Balance."

Parenteral Products Division

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BARD-PARKER
RIB-BACK
SURGICAL BLADES

and by any measure it is just as true today as when our Company was founded . . . in the purchase of B-P RIB-BACK SURGICAL BLADES you are provided with the most dependable cutting edges that modern scientific methods and *the art of accuracy* can produce . . . their performance in use is the answer to the question of economy!

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BARD-PARKER COMPANY, INC.
Danbury Connecticut, U.S.A.

QUALITY AND DEPENDABILITY • UNIFORMLY SHARP • ENDURING CUTTING EDGES

It's Sharp



RIB-BACKS packaged in the *new* RACK-PACK eliminates unwrapping, handling or racking of individual blades. A real *time* and *labor* saver for the O.R. personnel. *In a matter of seconds* from RACK-PACK to sterilizer.



(No. 70-62 PRIVATE ROOM GROUPING)

New–Hill-Rom series 7000 hospital furniture

designed by Raymond Loewy—color styled by Howard Ketcham

LISTED
FOR USE
WITH OXYGEN

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and featuring the Hill-Rom motor-driven Hilow Bed—listed by Underwriters' Laboratories, Inc., for use with Oxygen

● The creative genius of Raymond Loewy and Howard Ketcham and the master craftsmanship and experience of Hill-Rom are strikingly exemplified in this No. 70-62 Private Room Grouping. Here is a design that is not merely beautiful, but also refreshingly different. Note that the bed in this grouping is the Hill-Rom motor-driven Hilow bed, recently listed by Underwriters' Laboratories, Inc., for use with oxygen administering equipment of the nasal, mask type, and half-bed length oxygen tents. Write or wire for further information.

Other equipment in the above room scene includes: No. 7003 Bedside Cabinet, No. 70-614 Overbed Table, No. 70-26 Chest Desk, No. 70-08 Arm Chair, No. 70-07 Straight Chair, and No. 305 Lamp. The No. 70-61 manually operated Hilow Bed and No. 7001 standard height hospital bed are also available with this grouping.

HILL-ROM COMPANY, INC. • BATESVILLE, INDIANA

a HILL-ROM exclusive!





adjusts to high back comfort



HILL-ROM

NEW! Adjustable Back ARMCHAIR



wall-saver design

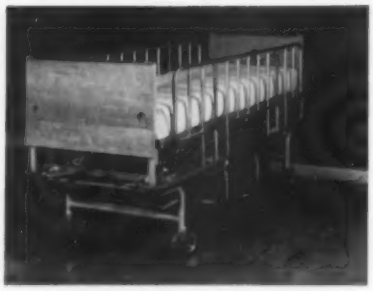
Now you can have high back chair comfort for your patients—and wall-saver protection for your rooms—without having to put up with those big, heavy, hard-to-move, wall-damaging high back chairs of yesterday. For this new Hill-Rom Arm Chair, despite its small size, gives high-back comfort in full measure! See how easily the nurse adjusts the back cushion by using the elevating rack. Another exclusive feature is the fact that the undercovers on the cushions are waterproof and stain-proof, and easily cleaned. The slip covers are removable.

Write for complete information on this and other new Hill-Rom chairs.

THE NEW

Hill-Rom

No. 42 Recovery Bed
Emergency Bed
Labor Bed
Eye Bed



- Equipped with Hill-Rom's No. 25 Trendelenburg Spring
- Telescoping Aluminum Sides
- Conductive Rubber Casters
- Six I.V. Rod Receptacles



- Removable End Panels
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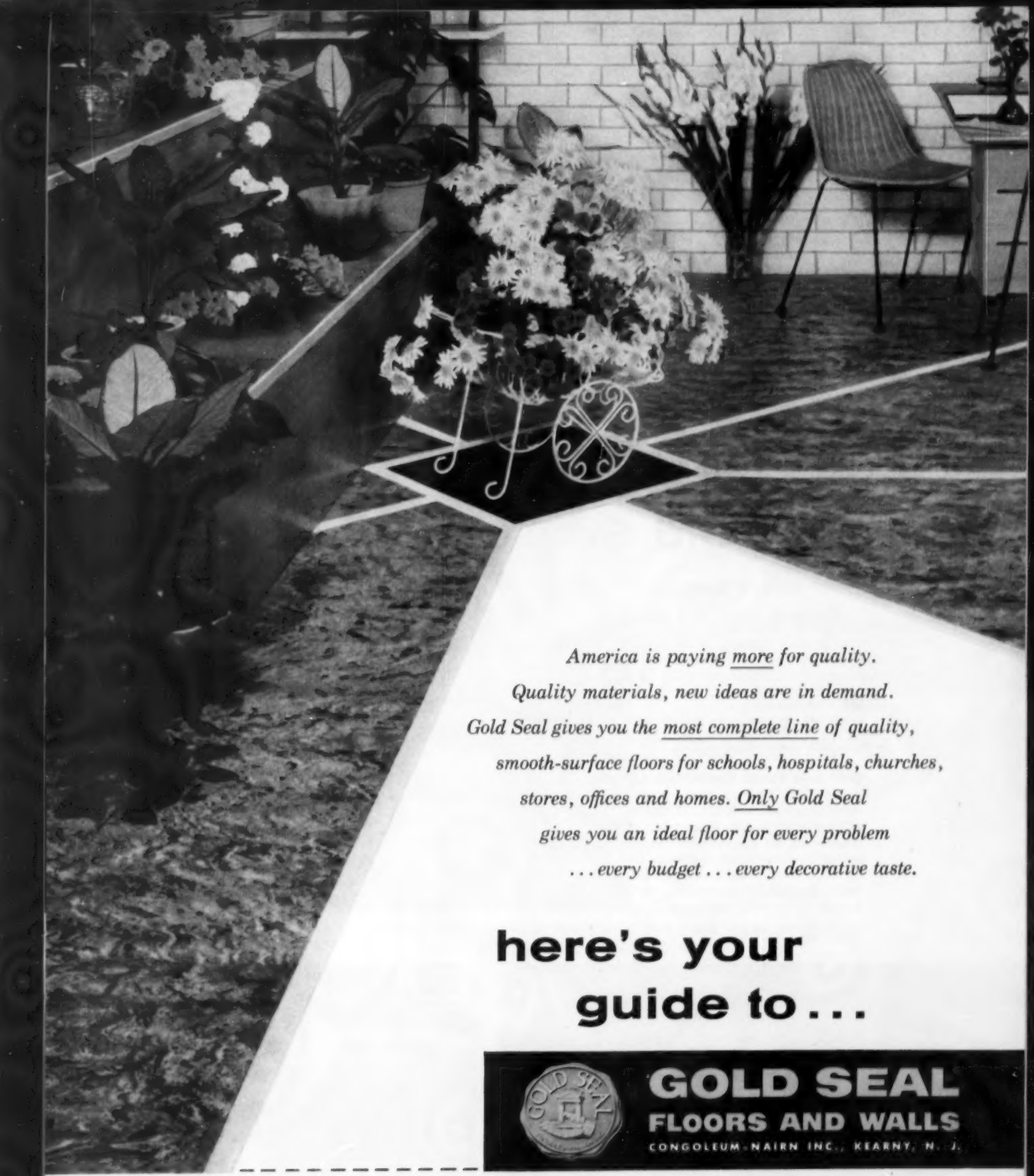
- Ideal as an Eye Bed

OTHER FEATURES:

- Wrap-around Bumpers
- Shelf for Utensils
- Used with Fracture Frames
- Used with Safety Step

For further information and free, full-color literature, write . . .

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Quality materials, new ideas are in demand.
Gold Seal gives you the most complete line of quality,
smooth-surface floors for schools, hospitals, churches,
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gives you an ideal floor for every problem
... every budget ... every decorative taste.

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GOLD SEAL
FLOORS AND WALLS

CONGOLEUM-NAIRN INC., KEARNY, N. J.

Gold Seal Inlaid Linoleum (illustrated above) . . . commercial gauge, 6′ wide by-the-yard. The *only* inlaid linoleum in America made by a natural oxidation process for greater resilience, greater durability! So tough and durable, installations *over thirty years old* are still giving great service. Easy to clean and keep clean. Resists dirt, grime, ordinary greases, oils. Cuts maintenance costs. Resilient . . . springs back under foot . . . resists permanent indentation. Flexible. Smart . . . in a wide range of patterns. Special design treatments can be easily created to direct traffic flow . . . separate areas . . . add a luxury look. 35 patterns. Burlap back. Guaranteed.*

More about Gold Seal Inlaid Linoleum —▸



Gold Seal Inlaid Linoleum Tile, *commercial gauge,* makes it easy to create smart decorative effects in commercial and institutional areas. Gives you all the benefits of the finest inlaid linoleum: resilience, durability, maintenance. Guaranteed.*

Gold Seal Inlaid Linoleum, *standard gauge,* meets the trend to smooth-surface flooring all through the house. Perfect, resilient, "basic" floors. Easy to clean. Long wearing. Smart patterns . . . including the most wanted linoleum in 4 consumer surveys . . . "Jackstraw"®! Guaranteed.*

Commercial gauge linoleum. Newark, New Jersey, City Councilmen's Office.

For low maintenance, long wear, smart patterns

Specify Gold Seal Inlaid Linoleum

Today's finest inlaid linoleum! More resilient! Quiet! Comfortable!
Easier to clean and keep clean! Resists dirt! Grease! Scuffing!
More economical! More durable! Cuts maintenance costs!
Smarter! Suggests hundreds of fresh design ideas!

SPECIFICATIONS:

Installation: Commercial gauge over suspended subfloors; over wood with lining felt, over concrete direct. Standard gauge with exclusive SuperFlex back, direct to suspended wood and concrete sub-floors.

Commercial gauge (⅛") Fed. Specs. LLL-L-367 and LLL-L-351-b, 6′ wide by-the-yard and 9″ x 9″ tile, burlap back. Patterns: 20 Veltone®, 4 Plain, 6 Battleship, 5 Jaspe.

Standard gauge—Fed. Specs. LLL-F-471, 6′ wide by-the-yard, 81 patterns; 9″ x 9″ tile, 36 patterns.

Gold Seal Static Conductive Linoleum is the only non-sparking linoleum that completely dissipates static electricity. Reduces hazard of explosion due to discharge of static electricity in areas where combustible gases are present. By far the most economical flooring protection against fatal anesthesia explosions. Gives you all the benefits of the finest inlaid linoleum: resilience, ease of maintenance, durability. **Specifications:** ⅛" gauge. Burlap back. 6′ wide by-the-yard. Fed. Specs. LLL-L-367. Guaranteed.*

Static Conductive Linoleum. Surgical Room. Chilton Memorial Hospital, Pompton Plains, New Jersey.

Gold Seal Ranchtile® Linoleum is an exclusive floor specially developed and proved for concrete slab on-grade installations . . . even with radiant heat. Easier to maintain and more soil-resistant than any other resilient tile . . . it's the perfect "basic" floor to use throughout on-grade homes. Resilient. Quiet. Comfortable. Long-wearing. **Specifications:** 9 beautiful, colorful, textured patterns in 9″ x 9″ tile. Standard gauge. Fed. Specs. LLL-F-471. Guaranteed* for homes, schools, motels.

Ranchtile Linoleum.





For a perfect all-purpose tile... on, above or below grade

Specify Gold Seal Vinylbest Tile

Resilient! Unusually durable! Fire-resistant! Goes anywhere!
Combines best features of other tiles! As moisture-resistant
as asphalt tile! As acid- and alkali-resistant as vinyl!
As rich in color as rubber tile! Stays bright and beautiful!



Amazing Vinylbest Tile takes practically any kind of abuse in its stride. It's as moisture-resistant as asphalt . . . as well as flexible, easily installed, resilient, beautiful, durable. More grease-resistant than so-called "grease-proof" brittle tile, it's a perfect, economical choice for restaurants, kitchens, cafeterias. Guaranteed.*

Specifications: Install Vinylbest on, above or below grade . . . over wood or concrete . . . with or without radiant heat. Use new Gold Seal "Three-Twenty" adhesive. 9" x 9" tiles. 14 patterns in $\frac{1}{16}$" gauge. 13 patterns in $\frac{1}{8}$" gauge. Unique foam marbleization. Fed. Specs. L-T-751.

Vinylbest Tile. Home Economics Class Room, Kearny High School, Kearny, New Jersey.

Gold Seal Vinyl Inlaids for floors, walls and countertops! So grease- and alkali-resistant . . . so easy to clean and keep clean . . . they've started a trend to light, glamorous floor colors all-through-the-house. Exclusive Bermuda Hues. Also marbleized colors. **Specifications:** *VinylFlor*, 6' wide, standard gauge. Install above-grade over concrete or wood. *VinylTile*, 9" x 9" standard gauge. Install on or above grade . . . over concrete or wood . . . even over radiant heating. *VinylTop* for beautiful, resilient, seamless, stain-resistant countertops in 17 patterns, 30", 36", 42" wide. Guaranteed.*

Floors and walls: "Bermuda Hues" VinylTile. Counters, cabinet facings: "Bermuda Hues" VinylTop.



For a million dollar look and luxurious quiet

Specify New Gold Seal Cork Tile

...even on-grade. *A new, improved cork tile with superior soil resistance!*

Smoother surface finish! Easier to clean and keep clean!

Richer, warmer cork color! A natural insulator!

Quiet! Comfortable underfoot!



New Gold Seal Cork Tile is made by a revolutionary process that gives it unsurpassed resistance to soiling. Minimizes characteristic burnt odor found in other cork tiles. Special factory finish gives it an extra smooth, highly polished surface. A natural insulator. Warm in winter. Cool in summer. Luxuriously sound-absorbent. Long wearing. Easier to install. Guaranteed.*

Specifications: 1/8" and 3/16" gauges. 6" x 6", 6" x 12", 9" x 9", and 12" x 12" die-cut tile. For on or above-grade. Beveled edges. Factory finish. Packed all light or random: light-medium-dark. Guaranteed for installation over on-grade concrete (even over radiant heating) with use of amazing new Gold Seal "Three-Twenty" adhesive.

On the floor: Random Patterns, Gold Seal Cork Tile.

On the wall: Light Pattern.

Gold Seal Asphalt Tile solves budget problems. Lowest initial cost in the industry for good-looking, moisture-resistant, durable flooring. Install where grease is not a problem . . . on, above or below grade. 27 handsome, marbleized patterns. **Specifications:** 9" x 9" and 18" x 24" tiles. 1/8" and 3/16" gauges. Fed. Specs. SS-T-306B. Guaranteed.*

***You and clients are assured of quality by the Gold Seal Guarantee ...satisfaction or your money back.**



Rubber Tile. Federal Savings and Loan, North Arlington, New Jersey.

Gold Seal Rubber Tile is today's prestige tile . . . beautiful, comfortable, impressive! The perfect flooring for dramatic custom designs . . . it gives you the greatest resilience as well as the clearest colors in the industry. Luxuriously quiet. Long wearing. 21 marbleized patterns. **Specifications:** 6" x 6" and 9" x 9" tiles. 1/8" gauge. Also in standard (.080") gauge for homes and light traffic areas. Install over suspended wood or concrete subfloors and over on-grade concrete . . . with or without radiant heat . . . Use Gold Seal "Three-Twenty" adhesive. Fed. Specs. ZZ-T-301A. Guaranteed.*

For home or business . . . you get the finest choice of all in

GOLD SEAL

GOLD SEAL

FLOORS AND WALLS

CONGOLEUM-NAIRN INC., KEARNY, N. J.

CLEANLINESS
NEATNESS
CONVENIENCE
ECONOMY

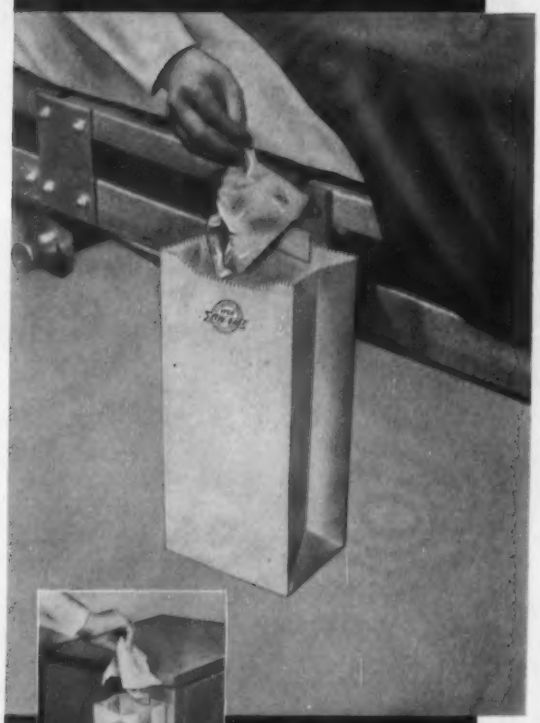
"In the Bag"

WITH THE NEW **IPCO**

STIK-BAG

PAT. PEND.

for BEDSIDE WASTE-DISPOSAL



STIK-BAG tabs on wherever you want it—to bed, cabinet, wall, bassinette stand, in the nursery, etc.

Sticks Firmly to Wood, Metal, Glass, Formica, Etc.
Peels Off Easily Without Marring Surface



1 - Slowly peel off protective white paper from tab.



2 - Apply cohesive tab to any smooth surface.

- Eliminates Costly, Cumbersome Wire Frame Holders.
- Eliminates Use of Unsightly Brown Paper Bags.
- Eliminates Pin-Hole Damage to Sheets.
- Eliminates Wasteful Use of Adhesive Tape.

Here is still another popular item in IPCO's long line of efficient overhead-cutting items! Aside from its many practical advantages, the IPCO "Stik-Bag" will pay for itself in savings on linens alone—so generally abused by use of damaging, tearing safety pins.

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INSTITUTIONAL PRODUCTS IPCO CORPORATION

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Institutional Products Corp.
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Gentlemen: Please rush me samples and prices of "Stik-Bag"

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Purchasing Executive _____

Superior broad-spectrum antibiotic with fewer

POLYCYCL

TRADE MARK

POLYCYCLINE CAPSULES



100 mg. — bottles of 25 and 100.
250 mg. — bottles of 16 and 100.

POLYCYCLINE SUSPENSION 250

Ready for use . . . requires no reconstitution.
250 mg. per 5 cc. — bottles of 30 cc.



Detailed information on request

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(TETRACYCLINE BRISTOL)

Note these advantages:

MORE EFFICIENT ANTIBIOTIC ACTION *with POLYCYCLINE than with older analogues* chlortetracycline and oxytetracycline. Polycycline is *more soluble* than chlortetracycline and is thus more rapidly absorbed and more widely diffused throughout the body. And, because Polycycline is also *more stable in solution* than either analogue, higher serum concentrations are achieved, even in the spinal fluid, and these levels are maintained for a longer time.

WIDE RANGE OF INDICATIONS *for POLYCYCLINE ... similar to its older analogues.* The broad-spectrum antibiotic efficacy of Polycycline includes both gram-positive and gram-negative bacteria, as well as certain rickettsiae, large viruses, and organisms developing resistance to penicillin.

FEWER SIDE EFFECTS *induced by POLYCYCLINE than by either analogue.* An important clinical advantage in the use of Polycycline is the greatly reduced frequency and severity of such reactions as nausea, vomiting, and diarrhea—which so often necessitate termination of treatment with older broad-spectrum antibiotics.



POLYCYCLINE
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For deep intramuscular injection. In single dose vials, 100 mg. per vial.



POLYCYCLINE
PEDIATRIC DROPS

For precision administration of small doses. 100 mg. per cc. — bottles of 10 cc. with dropper calibrated for 25 and 50 mg.

Requires no refrigerator space — since all dosage forms of POLYCYCLINE are stable for long periods at room temperature

Stock all dosage forms for the convenience of your staff

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MELMAC® DINNERWARE

saves $4,000-$6,000 in replacement costs yearly at The Citadel

THE MILITARY COLLEGE OF SOUTH CAROLINA





Another illustrious proving-ground for break-resistant dinnerware made of MELMAC molding material: *The Citadel*, serving over 5,000 meals a day! And, quite aside from MELMAC's low replacement cost, the college authorities and cadets like it for its colorful good looks.

The managers of dining operations, coast to coast, also like the ease and safety with which MELMAC can be washed in automatic dishwashers... the way it stacks and handles so quietly that patrons often comment ...and its light weight, a boon to those who carry the trays!

Like to get in on these advantages? Ask your supplier for genuine MELMAC!

MELMAC is a registered trade-mark of American Cyanamid Company, N.Y. 20, N.Y., supplier of MELMAC Molding Compounds to manufacturers who fashion high-quality dinnerware in a variety of designs and colors.

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PLASTICS AND RESINS DIVISION

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64 PERFECT CHEESEBURGER SLICES WITH ONLY 3 KNIFE CUTS... Kraft Ribbon Slices!

THE portion-control answer to profitable cheeseburger sandwiches are Kraft Ribbon Slices. Here's top-quality pasteurized process American Cheese actually *made in slices!* With only 3 knife cuts you get 64 perfect ¾-oz. cheeseburger slices in a matter of seconds. That's an average of 21 slices per pound!

Compare this to the time-consuming job of slicing loaf American Cheese by hand or machine—you realize only about 16 slices per pound and are bound to have waste in the form of slivers and broken pieces. What's more the slices won't be uniform in weight.

In contrast because each Ribbon Slice is a perfect portion—uniform in size, shape and weight—you can measure your costs to the penny! Be sure to order Ribbon Slices from your Kraft Institutional Representative the next time he calls!



Perfect portion-control slices in a jiffy

A with three knife cuts on red lines on package, you get 64 ¾-oz. cheeseburger slices.

B with two knife cuts on blue lines on package, you get 48 1-oz. sandwich slices.

KRAFT Foods Company INSTITUTIONAL DIVISION

KRAFT FOODS COMPANY
500 Peshtigo Court • Chicago 90, Illinois

THE NATION'S TASTE IS YOUR BEST BUYING GUIDE



Against streptococci

This is an actual sensitivity test with a strain of *Streptococcus pyogenes* on a blood agar plate. Note the high activity of ERYTHROCIN against this organism. This same streptococcus may be associated with *sinusitis . . . otitis media . . . tonsillitis . . . pneumonia . . . empyema . . . pharyngitis . . . septicemia . . . tracheobronchitis . . . streptococcal sore throat . . . scarlet fever . . . erysipelas . . . certain urinary tract infections . . .* and certain cases of *subacute bacterial endocarditis* and *osteomyelitis.*

specific therapy against the cocci...

Now, you can prescribe an antibiotic (*Filmtab* ERYTHROCIN) that is specific therapy for most bacterial respiratory infections. Specific therapy—because these infections are caused by staph-, strep- or pneumococci. *And the cocci are the very organisms most sensitive to* ERYTHROCIN. In fact, you'll find ERYTHROCIN more active against this group of organisms than many other antibiotics.

filmtab

Erythrocin® STEARATE

(ERYTHROMYCIN STEARATE, ABBOTT)

Against common intestinal flora

This sensitivity test shows ERYTHROCIN and the same antibiotics against a typical intestinal strain of *E. coli*. Note that ERYTHROCIN and penicillin do not affect growth of this organism—while the other antibiotics show marked inhibitory action. Since ERYTHROCIN is inactive against gram-negative organisms, *it is less likely to cause alteration in common intestinal flora—with an accompanying low incidence of side effects.*



...with little risk of serious side effects

The main reason is because ERYTHROCIN acts specifically. It destroys only harmful coccic invaders—yet doesn't materially change normal intestinal flora. *Thus, your patients rarely get side effects from* ERYTHROCIN. Nor do they get the allergic reactions sometimes seen with penicillin therapy. *Filmtab* ERYTHROCIN (100 and 200 mg.) comes in bottles of 25 and 100. Won't you prescribe *Filmtab* ERYTHROCIN—soon? Abbott

filmtab **Erythrocin®** STEARATE

(ERYTHROMYCIN STEARATE, ABBOTT)

TO INCREASE THE COMFORT OF THE PATIENT



EASIER FOR YOUR NURSES TO OPERATE

Choose

LUDMAN Auto-Lok AUTOMATIC LOCKING WINDOWS

SEALS TIGHTER THAN A REFRIGERATOR • • • •

Your hospital board can profit by the experience of other boards that have earned the gratitude of patients and community alike by adding more comfort to every room, and yet achieving lower maintenance costs and greater operating ease through the use of Auto-Lok windows.

Countless successful hospital installations, continuing work with the architects of hundreds of America's most modern hospitals, and the specialized skills gained through designing and producing windows for outstanding public buildings . . . . all contribute to Ludman's leadership in hospital window installations.

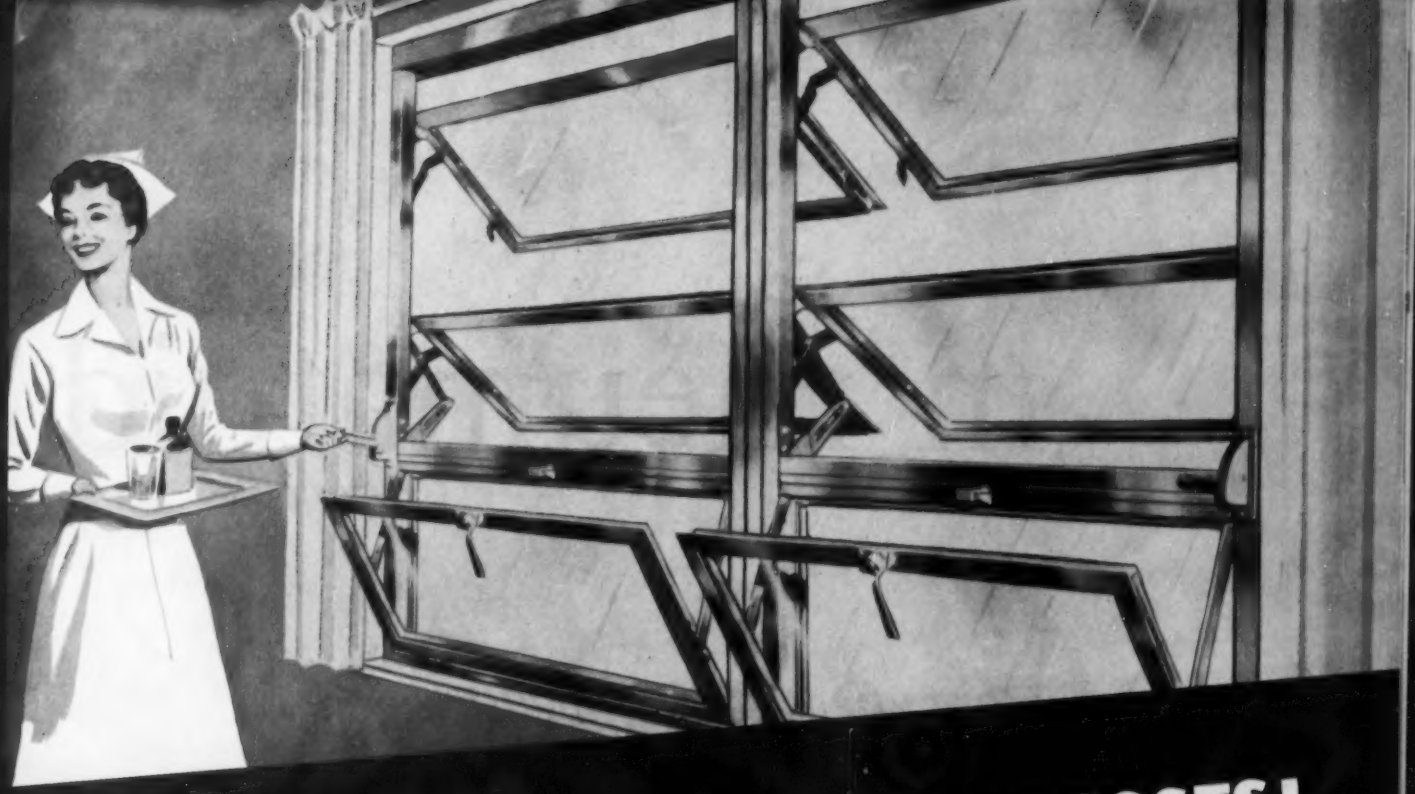
The coupon below will bring you, in full detail, the information you need to look ahead in your selection of hospital windows. To learn why Auto-Lok windows meet the ten most important requirements that experts* agree are really important in a window . . . . to learn how Auto-Lok windows insure healthful fresh air, even when it's raining . . . . to learn of such savings as reduced fuel costs . . . . to learn how you save with windows that are washed from inside . . . . send the coupon today.

*Geoffrey Baker and Bruno Funaro in "Windows in Modern Architecture".

SPECIALISTS IN BUILDING HOSPITAL WINDOWS . . . .

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LEADS IN WINDOW ENGINEERING



WITH LOWER MAINTENANCE COSTS!



Another fine modern hospital chooses Auto-Lok Windows

Manatee Veterans Memorial Hospital, Bradenton, Florida

Architects & Engineers: Bail, Horton & Associates

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Please send me all the information on why Ludman's AUTO-LOK windows mean so much to the patient . . . . yet save money on the budget!

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Street . . . . . .

City . . . . . Zone . . . . . State . . . .

in rheumatoid

more effective therapeutic agent than older corticosteroids

Three to five times as potent as oral cortisone or hydrocortisone, milligram per milligram, METICORTEN provides enhanced anti-inflammatory and antirheumatic action without the major undesirable effects associated with older corticosteroids.

Within 24 hours after administration of METICORTEN, joint pain decreases, and stiffness and local heat diminish. Improvement in functional capacity and mobility follows quickly.[1,2] Excellent results are obtained even in patients no longer responding to cortisone or hydrocortisone.[1,2]

And in intractable asthma, METICORTEN controls symptoms rapidly, markedly increases vital capacity, and permits patients to resume normal activities promptly.[3,4]

Dosage and Administration

METICORTEN is available as 5 mg. scored tablets in bottles of 30 and 100. In the treatment of rheumatoid arthritis, dosage of METICORTEN begins with an average of 20 to 30 mg. (4 to 6 tablets) a day. This is gradually reduced by 2½ to 5 mg. until maintenance dosage of 5 to 20 mg. is reached. The total 24-hour dose should be divided into four parts and administered *after meals and at bedtime*. Patients may be transferred directly from hydrocortisone or cortisone to METICORTEN without difficulty.

arthritis

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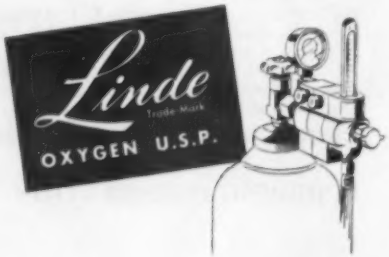
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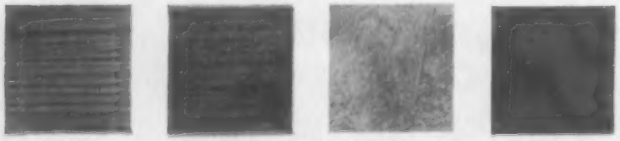
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SMALL HOSPITAL QUESTIONS

Food for the Aged

Question: Would it be possible for you to send me suggestions on easily masticated and digested foods for elderly patients? A number of our patients are over age 65 and are unable to take solid foods.—T.L.F., Ont.

ANSWER: The American Dietetic Association at 620 North Michigan Avenue, Chicago, has an excellent pamphlet, "Eating Is Fun for Older People, Too." The association also has printed material directed to the older people themselves. Most textbooks on nutrition and dietetics for nurses incorporate material applicable to feeding aged patients. Also the "soft diets" in many diet manuals may be consulted for suggestions. The many brands of canned baby foods now available—fruits, vegetables and meats—are just as useful for the toothless adult as for the toothless infant. For nutritional aspects of diets for aged patients the reader may consult a report of the A.M.A. Council on Foods and Nutrition, "Nutrition Problems of Geriatric Medicine," which appeared in the *Journal of the A.M.A.* for April 8, 1950.—MARY P. HUDDLESON.

Tax on Food and Lodging?

Question: Several of our employes, while preparing their income tax returns last month, raised a question about reporting the value of meals and lodging, where these were furnished by the hospital. We indicated in each instance that these were not reportable since they were furnished, as part of the employment arrangement, for the convenience of the hospital. This decision has been questioned. Were we correct?—A.M.K., Colo.

ANSWER: Section 119 of the Internal Revenue Code of 1954 clarified the tax status of meals and lodgings furnished an employe by his employer. In brief, it provides that their value is to be excluded for tax purposes from the employe's income if they are furnished for the convenience of the employer. In the case of meals, this rule applies where the meals are furnished on the business premises; in the case of lodging, where the employe is required to accept such lodging on the business premises of his employer, as a condition of his employment. A recent ruling of the Internal Revenue Service includes the following:

1. An employer is not required in 1954 to withhold income tax upon the value of meals and lodging if such value is clearly excludable from the gross income of the employe by reason of section 119.

2. No adjustment between the employer and his employe is required with respect to income tax withheld during the calendar year 1954 on the value of such meals or lodging, but if the employer desires to make such adjustments, he may do so.

Employes per Patient

Question: We are a 50 bed hospital with an average occupancy of 35 patients, or approximately 70 per cent of capacity. We have only 32 full-time employes, or less than one employe per patient. I keep seeing in hospital literature and publicity that the national average is two employes per patient and wonder if this is correct, or if we are seriously out of line with existing practice?—R.E., Ore.

ANSWER: According to the "Prototype Studies" made by Dr. Louis Block, formerly of the Division of Hospital Facilities, U.S. Public Health Service, your payroll is in line with existing practice for 50 bed hospitals, with the exception that these hospitals commonly have a dozen or more part-time employes, in addition to the regular, full-time payroll. The national average (actually less than two employes per occupied bed) includes the larger hospitals which have many services and departments, such as the outpatient department and many specialized services not commonly found in hospitals of your size and classification.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

How to Allocate Space

Question: We are planning an addition which will add two more nursing units to this hospital of 100 beds. Opinion on the board of trustees, and among the doctors, is divided on the question of how to apportion new space among private, semiprivate and larger accommodations. Some say the trend is toward having all private rooms; others insist these accommodations would be too expensive, and occupancy would suffer. One board member has suggested all the rooms be made the size that would permit use as either one-bed or two-bed rooms. What is the current practice and thinking on this subject?—J.W.C., Fla.

ANSWER: Of course, the economic situation in your own community, determining the type of accommodation used by the majority of patients, must be considered in any such decision. Generally speaking, however, opinion among hospital authorities is probably divided along the same lines as it is within your group. Nevertheless, there is certainly a trend toward increasing the ratio of private to semiprivate accommodations. With the exception of one study, made in a single hospital in New York City recently, which shows a preference for multiple bed accommodations, all recent surveys indicate most patients want privacy.

In many hospitals built recently, small private rooms, planned to economize as far as possible on space, have proved popular with patients and, it is found, can be operated successfully at rates not much above those charged for two-bed accommodations. While a number of hospitals have compromised on the size room that can be used for either one or two beds, others complain that this plan is neither successful nor practical: Either the room is so large that it looks barren and far from comfortable when the second bed is removed, or it is so small that it is crowded and inefficient when the second bed is added. In general, it would appear that modern practice is approaching the time envisioned by a leading hospital authority who attacked the concept of the semiprivate room many years ago. "Which half of the patient is private?" he wanted to know.



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wire from Washington

REINSURANCE

These are the weeks when Congress really is digging in on its job. All the preliminary political adjustments have been made and accepted. Republicans realize they aren't running the show this year, and Democrats realize that although they have committee control, they can't do too much without the cooperation of the Republicans. So work is being done on the committee level, and there are some indications of what bills have priority and what bills are done for.

It may be too early for the final word, but as of now there is no suggestion that the President's plan for reinsurance of health insurance plans will be the big issue it was last year. It is still strongly opposed by the American Medical Association and by most of the insurance industry. There is nothing official yet about the American Hospital Association's position on reinsurance, but the A.H.A. is not likely to show any more enthusiasm than it did last year, when its support for the bill was more official than ardent.

MORTGAGE FINANCING

Another of the Administration's major bills—for guarantee of mortgages on health facilities—is still stranded and more than likely will remain that way. It faces the continued opposition of the American Medical Association and the new opposition of A.H.A., which did not testify on this bill last year. So the prospects are not too bright for these two bills that Secretary Hobby says head the Administration's list.

On reinsurance, there may be a face-saving device in the making. The insurance industry itself is attempting to work out a private, nongovernmental reinsurance fund. This would allow the Administration to withdraw its bill, explaining that a federal fund is no longer necessary. On mortgage guarantees, the Eisenhower-Hobby crowd may not have to run the risk of a defeat. There are three possibilities: (a) that no hearings will be called, (b) that if there are hearings they will be mere formalities, and (c) that the Democrats will offer their own bill as a substitute.

MILITARY DEPENDENTS

Early in the session prospects were that the Administration's bills for better medical care for military dependents and for a contributory health insurance plan for government employes would be enacted without much delay. Now the situation has changed. Ironically, pay raises for military personnel and for federal civilian employes may cool off Congress' interest in these health bills. In both cases the feeling is growing that if pay raises are given out this year, any other expensive benefits should be held off at least until next year.

If the dependent care issue is postponed, quite an argument will be averted. The Defense Department still believes that the military hospitals and uniformed physicians should take care of most of the dependents. But the civilian profession thinks it should work the other way, with the military caring for only those dependents who can't receive adequate care from civilian sources.

The A.H.A. doesn't like the all-military look of the bill. It is suggesting that dependents be covered by contributory health insurance, with the military physicians and military hospitals entering the picture only where civilian facilities are not available. The A.H.A. is proposing that the insurance include diagnostic procedures, prenatal and postnatal care, and preventive services.

The A.M.A. also is making suggestions along these lines. Thus there is the good prospect that a compromise can be worked out, particularly if no action is taken this year.

FEDERAL EMPLOYES

On a health insurance plan for government workers, the situation is not the same. A few technicalities still have to be agreed upon, but there is no important opposition to the proposal. If the Budget Bureau and the committees give the green light, this bill easily could become a law this session. But so far there are no green lights.

MENTAL HEALTH

On the positive side, the picture also is clearing up.

Moving directly toward enactment is a Democratic bill for a national survey of mental health problems. This seems to be everybody's favorite. There is no opposition at all, and the amount involved, a million and a quarter dollars, is not enough to cause real worry. Along with this, the Congress also might enact an Administration bill to spend more money in U.S. grants to states for mental health work.

The need for more U.S. legislation on mental health, a subject that is almost devoid of controversy, is the first health subject to occupy the attention of Congress. The House interstate and foreign commerce committee held four days of hearings on two bills. One was an Administration bill to step up U.S. grants to states for the usual mental health work, and at the same time to set up a new program of special grants. The other was the proposal for the U.S. to give money to outside professional groups—such as the American Psychiatric Association—for a comprehensive study of the problem and suggestions of how much to spend and how to spend it.

To psychiatrists—and most people familiar with the hospital picture—there was nothing new in the statistics presented at the hearing. The incontrovertible fact is that of all the patients who enter mental hospitals, not more than 50 per cent can expect to come out alive. Once they have been in more than eight years, there is almost no chance, statistically, that they will ever leave a mental institution. The cost is the greatest single medical cost on the nation—possibly as high as two and one-half billion dollars annually, when loss of earnings is counted. Half the nation's hospital beds are occupied by mental patients, but only 5 per cent of the nation's medical research money is spent on mental illness.

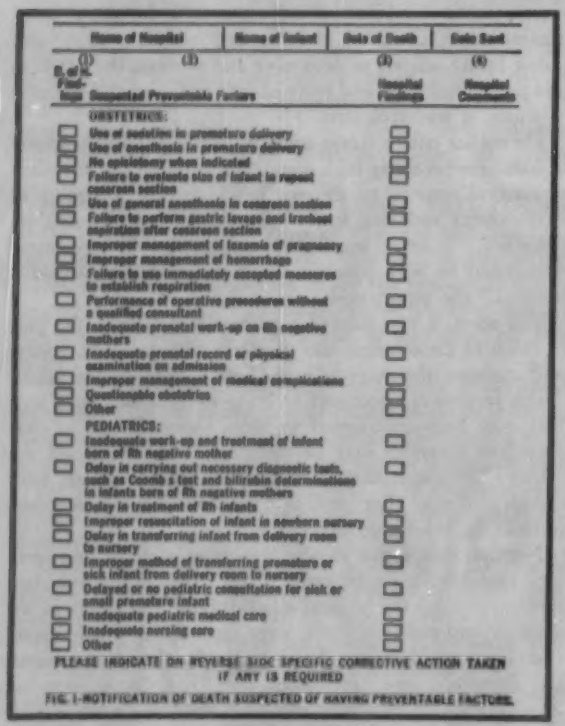
followed, will lead to more accurate and complete records. The rôle of the Chicago Board of Health, it was explained, was to prepare statistics to show hebdomadal death rates, based on the total of all deaths as well as only on deaths with preventable factors, for each month for all hospitals with maternity divisions. These rates can be subjected immediately to analysis and study, and are graphically shown on an "alerter system" maintained by the Board of Health, which makes it possible for rates of the several hospitals to be easily and rapidly compared.

Hospitals with a record of faulty practices are kept under the constant surveillance of the staff of the Board of Health, Dr. Bundesen said.

"By means of this alerter system, the staff of the Board of Health, working closely with hospital administrators, nurses and physicians, immediately calls the occurrence of hebdomadal deaths with preventable factors to the attention of all the individuals concerned," the article said. "Attention is called to possible breakdowns by high hebdomadal death rates. What is more important, the system also vividly points out day by day the hospitals in which deaths with preventable factors have occurred and continue to occur. In addition, it also constantly keeps the staff of the Board of Health alerted to the need for immediate corrective action, so that the hospitals involved may be promptly notified. It further shows when such corrective action has been taken.

"It is the duty of the hospital administrator to institute stronger measures if necessary to assure strict adherence to the regulations and operation of the maternity division in accordance with accepted practices and procedures, so that the hospital maternity division may continue to function."

To set the system in motion, it was explained, a notification form for deaths suspected of having preventable factors is sent to the hospital as soon as possible after the death occurs. (see Fig. 1) "The hospital is requested to study and check the record of the case," the report said. "This procedure has a three-fold purpose: (1) To make the hospital administrator immediately aware of the occurrence of a death suspected of having preventable factors, (2) to stimulate the response of the hospital personnel to study such deaths immediately and to take corrective action when necessary, and (3) to provide a check on the validity of the Board of Health findings.



Name of Hospital		Name of Infant	Date of Death	Date Sent
(I) No. of Findings	(II) Suspected Preventable Factors		(III) Hospital Findings	(IV) Hospital Comments
	OBSTETRICS:			
☐	Use of sedation in premature delivery		☐	
☐	Use of anesthesia in premature delivery		☐	
☐	No episiotomy when indicated		☐	
☐	Failure to evaluate size of infant in repeat cesarean section		☐	
☐	Use of general anesthesia in cesarean section		☐	
☐	Failure to perform gastric lavage and tracheal aspiration after cesarean section		☐	
☐	Improper management of toxemia of pregnancy		☐	
☐	Improper management of hemorrhage		☐	
☐	Failure to use immediately accepted measures to establish respiration		☐	
☐	Performance of operative procedures without a qualified consultant		☐	
☐	Inadequate prenatal work-up on Rh negative mothers		☐	
☐	Inadequate prenatal record or physical examination on admission		☐	
☐	Improper management of medical complications		☐	
☐	Questionable obstetrics		☐	
☐	Other		☐	
	PEDIATRICS:			
☐	Inadequate work-up and treatment of infant born of Rh negative mother		☐	
☐	Delay in carrying out necessary diagnostic tests, such as Coomb's test and bilirubin determinations in infants born of Rh negative mothers		☐	
☐	Delay in treatment of Rh infants		☐	
☐	Improper resuscitation of infant in newborn nursery		☐	
☐	Delay in transferring infant from delivery room to nursery		☐	
☐	Improper method of transferring premature or sick infant from delivery room to nursery		☐	
☐	Delayed or no pediatric consultation for sick or small premature infant		☐	
☐	Inadequate pediatric medical care		☐	
☐	Inadequate nursing care		☐	
☐	Other		☐	

PLEASE INDICATE ON REVERSE SIDE SPECIFIC CORRECTIVE ACTION TAKEN IF ANY IS REQUIRED

FIG. 1-NOTIFICATION OF DEATH SUSPECTED OF HAVING PREVENTABLE FACTORS.

Essentially, the alerter system maintained in the downtown offices of the Board of Health is a colored card and flashing light arrangement which groups and identifies the hospitals on a display board, according to their current hebdomadal death rates. Two sets of death rates are shown, one indicating the hospital's performance and ranking on the basis of all hebdomadal deaths, another showing the performance and ranking on the basis of hebdomadal deaths with identified preventable factors.

For example, a flashing red signal light alongside a hospital's monthly hebdomadal death rate card indicates that one or more hebdomadal deaths known or strongly suspected to have major preventable factors have occurred in that hospital. Thus the flashing red signal indicates the hospital is under surveillance to determine whether or not faulty practices and procedures have contributed to the deaths.

A flashing blue signal light alongside the hospital's death rate card indicates the hospital has had an hebdomadal death with preventable factors and has an unsatisfactory record of past hebdomadal deaths. "Blue light" hospitals are chosen by the president of the Board of Health to be contacted and informed of the record, it was explained.

A flashing gold signal light alongside the hospital's monthly death rate card is an indication of merit, calling attention to the fact that the administrator and staff members have followed all statutes, ordinances, rules and regulations strictly and wholeheartedly.

In addition to the master control panel with its cards and lights showing hospital ranking according to hebdomadal death record, the alerter system includes separate panels showing hospital performance in connection with individual deaths, and deaths of premature infants.

The article concludes with detailed reports of experience with several individual hospitals, showing improved performance following application of the investigative, reporting and follow-up system.

"These deaths can be eliminated by correcting all faulty practices," Dr. Bundesen concluded. "None of these institutions wanted to have needless deaths, but they just were not aware of their occurrence. We have only once encountered resistance at any institution to adherence to the regulations that required revocation of the hospital license, but rather we have met with excellent cooperation and helpful assistance on the part of the hospital administrators and chiefs of the obstetric and pediatric staffs."

The Modern Hospital
MAY 1955



LOOKING AROUND

Contract Practice

WHEN our old friend Anastasia was in the office the other day, we showed her a clipping we had been saving. It was about the New York radiologist who spends his week ends singing basso profundo in the City Center opera. Recently, it was reported, he sang the role of Sparafucile in Verdi's Rigoletto.

"Sparafucile," we reminded Anastasia, "is the raffish innkeeper who hires out as an assassin, tying his victims up in sacks."

"Fee for service?" Anastasia asked.

End of Argument

WITHIN a few hours after announcement of the success of clinical trials of the Salk polio vaccine, huge supplies of the vaccine were moving from the licensed manufacturers to health departments, hospitals and physicians' offices, and the mass inoculations were under way. In a few weeks, it is expected, 9,000,000 children in the first and second grades will have received the vaccine. Soon afterward, an estimated 30,000,000 to 40,000,000 persons will be protected. As medical authorities stated at the time of the announcement, this does not mean that poliomyelitis will vanish overnight. It does, however, foretell an end to the dreadful epidemics that have brought death, suffering and anxiety to so many communities in years past, and an end to the overwhelming, heartbreaking burdens the doctors, nurses and hospitals in these communities have had to assume.

Certainly the world owes everlasting gratitude to Dr. Salk and all his associates and predecessors whose scientific energy and skill made the vaccine possible, and to the National Foundation for Infantile Paralysis, and all its workers and contributors, whose support underwrote the efforts of the scientists. Equally, however, we should be thankful for the triumph of human organization which made it possible for the vaccine, once approved, to be so quickly available to so many millions. Under the Foundation's plan and financing, manufacturers and distributors, local health departments, medical societies, public and parochial school authorities, hospitals and individual physicians were swiftly mobilized to bring protection immediately to the most susceptible groups.

There were some hitches, as when the Chicago Medical Society, with the medical profession's unerring genius for putting its worst foot in its mouth, made some honest misgivings (see page 156) about a principle ("whether a national lay organization should determine that an immunization must be carried out in only one way") look like ill-tempered heel-dragging over who would get the fees. Other medical groups, however, came forward quickly with reassuring policy statements. The New York County Society, for example, urged physicians to administer the vaccine "at reasonable fees," and the board of directors of the American Academy of General Practice publicly requested the nation's family doctors "to make sure no patient is denied this vaccine for financial reasons." In many communities, hospitals moved promptly to offer their facilities and staffs to aid in administration of inoculations.

It is doubtful that ever before in history have so many people received medical care in so short a time. Thus the great lesson of the Salk vaccine is that, given sufficient urgency, our private physicians and voluntary medical institutions can operate with all the speed and efficiency that are claimed for systems functioning under government control. Hereafter, it seems to us, the arguments for socialized medicine need never be answered with the kind of silly, irrelevant arm-waving about Communist dictatorship that appears on the next page. Instead, the argument can be cut short with a single phrase telling the finest chapter of free medicine's great story: "Remember the Salk vaccine!"

Duty to Inform

HOSPITAL trustees and administrators who fear the trouble that can result when a staff member has to be disciplined should read the opinion issued recently by Judge Clifford L. Belt of Marysville, Ohio, who ordered a jury in the Union County common pleas court there to return a verdict of innocent in a $20,000 slander suit brought against a colleague by Dr. Charles E. Bolinger. Dr. Bolinger was dropped from the staff of Union Memorial Hospital three years ago and has been suing somebody or other ever since.

"It appears there has been much ado about nothing in these cases," said Judge Belt. "The cases have been puffed up and talked about and published as though they were unusual, and that isn't true at all. This is just a very ordinary case, and inasmuch as the plaintiff was not asking and is not entitled to any damages beyond a nominal sum, it poses a question as to why the case is here.

"The average lawyer has had worse

things said about him many times by many people than are found in the petition in this case. The average doctor has stories spread about him, about how he mistreated some patient or another. Professional men must expect those things. I dare say the plaintiff in this case has not lost a patient and is practicing medicine just as he always did. As a matter of fact neither he nor anyone else has been damaged as far as this case is concerned."

Basis for the judge's ruling was that the alleged damaging statements about the plaintiff were made in a hospital staff meeting and thus were privileged under the law. "When the publication is made because the maker is under some obligation to give information about the person concerned, he also owes a duty to the person to whom the statement is made not to mislead him by withholding information received and honestly believed to be true," the court held. "The law protects the person making the statement in such cases if it was made in good faith in an effort to discharge his duty of giving information, and with an honest belief in its truth."

In giving information about the plaintiff, the defendant staff member was performing a professional duty, Judge Belt ruled: "Physicians have a special duty to relieve the suffering of mankind, and that is a special duty which extends throughout the community in which the physician practices his profession," the judge said. "That is one of the most important duties falling to the lot of men, and physicians ought to see to it, as far as they can within the law, that those who are incompetent or those who take their profession lightly are punished, or at least that people find out about them."

Following the verdict, Dr. Bolinger was quoted by newspapers as saying, "It's been a lot of fun"—a view that is not likely to be shared by members of the hospital's board of trustees. At one point following Dr. Bolinger's dismissal from the staff, a meeting of hospital trustees was invaded by a group of citizens demanding that the hospital extend privileges to any physician licensed by the state and residing in the county.

Following its next meeting, the board issued a public statement indicating its policy would remain unchanged. Reviewing requirements for membership on the staff of an accredited hospital, the board said: "We have not been able to find an alternative feature to limited staff membership, and apparently that has been the history of most other hospitals. The medical staff must discipline itself and if it is to do so it must, as a group acting by majority, determine its own membership.

"A conscientious effort has been made to study all the problems involved, to consult with experts in the field on difficult problems, and, most important, to be guided by the successful experience of other hospitals," the board concluded. "We recognize the problems of those citizens who are denied admission to this hospital because their doctor is not a member of the staff. There are bound to be some inequities in every situation and we desire to correct as many as possible, if someone will show us the way. The issues have been joined in court and they should be settled there. Meanwhile, the board must remind the citizens of the county that patients are admitted to the hospital only by advance arrangement by a staff doctor. When an emergency case is brought to the hospital, the patient has choice of any available staff doctor. If he has no preference, the doctor on call will be summoned."

Hospital Week

THE true meaning of National Hospital Week, the feeling that so many people will seek to convey in all the speeches, tours, proclamations, releases, posters and bulletins that will be turned out this month, may be found, it seems to us, in this simple story:

From the remoteness of a small rural hospital, a young nursing supervisor journeyed to New York to spend several weeks studying and working in a large cancer research hospital. "One day," she related, "I remarked to the head nurse in one of the clinics, 'However do you keep up your courage and your spirits when you see so many of these patients coming back again and again, each time progressively worse?'

" 'Come with me and I'll show you,' the head nurse replied. She led the way upstairs to a landing whose window looked out on innumerable buildings covering an entire city block.

" 'When I become discouraged and depressed,' she explained, 'I come here and as I look out, I think of all the men and women in these buildings who are devoting their lives to trying to find the answer to this dreaded disease. I think of those who are volunteering their time, their efforts and their money to help the unfortunates who enter our doors. I thank God for all of them—and I return with renewed faith that their efforts will not be unavailing.' "

Out Where It Grows

FROM the Hill-Burton Act to Communist dictatorship is a long leap, but an intrepid medical philosopher, Dr. G. V. Caughlan of Council Bluffs, Iowa, president of the Iowa State Medical Society, made it recently in a single page of the society's *Journal*.

"Never has the threat to our profession been so ominous as now," Dr. Caughlan warned. "The expanded Hill-Burton Act, together with the regulations that the Health, Education and Welfare Department has set up for its administration, presents an awesome picture to organized medicine and to physicians. Apparently, it is designed to place hospitals in control of the practice of medicine, and, so far as professional work is concerned, to make physicians their captives."

To combat the hospital menace, Dr. Caughlan urged physicians in every Iowa village and town to take the stump. "Each physician must address service clubs, veterans organizations, lodges, church groups and farm organizations," he declared. "In addition, he must talk with his patients of the peril that his profession is facing. The public must be told that when medicine becomes socialized, it is probable that other sections of our economy will follow along. From that point, it will be no more than a short step to Communism and dictatorship for America."

See what they mean about Iowa?

Basic Problem in Blood Banks: FREE OR PAY

The national Blood Foundation is a step in the right direction, but before a uniform blood banking system can be developed we must resolve the basic issue of "something for nothing" vs. "pay as you go"

DONALD E. BROWN, M.D.
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WHEN the national Blood Foundation was finally chartered this spring, after a year or more of preliminary discussions among the interested agencies,* the occasion was hopefully acclaimed by many hospital people as the end of a chaotic period in the collection and distribution of blood for civilian use. Soon nationwide standards would emerge, it was hoped, which would enable hospitals with blood banks to adopt the same practices used elsewhere and help hospitals without banks find their place in the long hoped-for network of blood donor and distribution stations.

Actually, these goals now seem as far away as ever. Before they can be reached, or even approached, the foundation and its constituent organizations, and their memberships, must face and decide some major questions of policy that all the previous discussions have not yet fully resolved. Briefly, there are three possibilities:

1. Development of a blood banking system run largely by nonprofessional personnel and based, either by direct statement or by implication, on the ultimate doctrine of "something for nothing."

2. Development of a system run largely by professional personnel and based on the economic doctrine of "pay as you go."

3. A compromise system that would lie somewhere between these extremes and have some of the characteristics of each.

In order that the current situation may be thoroughly understood, it should be viewed with historical perspective. The first blood bank was established by the British army during World War I. In the 1920's a few "walking donor" blood banks were established in this country. Their quality was considerably improved by the founding in 1929 of the Blood Transfusion Betterment Society of New York. Because of problems with anticoagulants and preservatives, blood could not be kept for any appreciable length of time, but gradual improvements in technic allowed Cook County Hospital, Chicago, to open the first real blood bank in 1935.

At the outset of World War II, however, there were only a couple of dozen blood banks in the entire country. The creation of new blood banks was encouraged at that time by the Office of Civilian Defense in the form of money grants to be matched by the hospitals.

In 1940, with European war clouds swirling closer to our shores, the surgeons general of the army and navy designated a medical officer in each service to devote full time to the problems of blood banking. The United States Public Health Service, through the National Institutes of Health, began to develop the standards which were later to be used in the licensing of commercial firms processing blood for the armed forces.

At the request of the surgeons general of the services, the National Research Council organized its subcommittee on blood substitutes. A program for the procurement of plasma was organized by the Blood Transfusion Association of New York and through the cooperation of both the American and the British Red Cross the plasma procured was shipped to the British army.

On June 14, 1940, the surgeon general of the army requested that 1000 donors be enrolled for research purposes, and in September the surgeon general of the navy made the same request. Procurement was begun on September 9 under the Southeastern Pennsylvania chapter of the American Red Cross in Philadelphia. On November 30 the subcommittee on blood substitutes of the National Research Council recommended to the surgeons general of the army and navy that they request the American Red Cross to organize a blood procurement program for the purpose of servicing the armed forces. Acting on this recommendation, the surgeons general initiated a joint undertaking with the American Red Cross and the National Research Council.

Early in 1941, plans were completed for the procurement and processing of 15,000 units of dried plasma. On February 4 the American Red Cross Blood Donor Service was initiated, the first voluntary donors being recruited by the

*The American Hospital Association, American Medical Association, American National Red Cross, American Association of Blood Banks, and American Society of Clinical Pathologists.

DR. BROWN UNDERRATES RED CROSS STRENGTH: GRANT

1. ALL DETAILS OF THE RED Cross blood program are under the direction of a physician who is administratively responsible only to the president of the American Red Cross. The physician at the top receives assistance from a professional staff consisting of administrative and medical specialists. A doctor of medicine heads each area blood program office and one heads each regional program. Venipunctures are performed by registered professional nurses and the blood is then tested by qualified laboratory technicians. We require the presence of a licensed M.D. at the time blood is collected; and we operate only in those counties where written permission has been received from the medical societies, hospitals and health departments. County medical advisory committees frequently make constructive suggestions about the regional operations.

2. The American Red Cross is financed completely by voluntary private contributions. The organization has never received government money to operate its civilian blood programs. In 1950 the existence of a privately financed chain of locally sponsored blood programs may well have forestalled the development of a real government-sponsored national blood program to meet the demand for blood that grew out of the Korean emergency.

3. Under Red Cross sponsorship the local medical society, health department, and hospitals determined the best way to solve local blood problems. Some areas selected the Red Cross regional blood program. Many others did not. Basic to the establishment of a Red Cross program was the approval of the local medical society and the establishment of a medical advisory committee which would supervise the regional program, recommend the director of the center (M.D.), and give approval to the employment of other medical and technical personnel.

4. We are unaware of the locale of the basic differences referred to in the article. The Red Cross furnishes blood to, and maintains amicable relations with, more than 3500 hospitals. Further, the Red Cross throughout the country exchanges blood with scores of hospital and community blood banks with no apparent difficulty. We do not believe the relatively few hospital and community blood banks that entertain the views set forth by Dr. Brown represent national thinking. Here we encounter the nub of the conflict between the numerically dominant people who share the Red Cross philosophy and the dissident minority. After all, man himself is an aggregate of biologics.

5. Red Cross operations unquestionably do not lead hospitals into debt. On the contrary, participation in the program has replaced very costly and uneconomical methods which most hospitals cannot pursue without instituting charges too heavy for the patients.

6. The uninformed reader might conclude that the Red Cross provides only a small portion of the blood used in American hospitals, which is far from the truth. Some Red Cross centers were established for and do provide total coverage. It was never the Red Cross intention to engage in more than a supplementary rôle in most metropolitan areas.

7. Irrespective of the agency, blood collection and distribution entail cost. Red Cross has chosen to finance through voluntary contributions rather than by making direct charges. Our plan of hospital financial participation has discouraged waste of blood and made its usage generally more economical.

8. Although the differences between our philosophical viewpoints on the collection of blood and its distribution seem to be irreconcilable, I have respect for Dr. Brown's opinions. I am convinced that he vastly underrates the Red Cross program's continuing strength, and growth and solidification. The program is with us to stay, not so much through the will of various organizations but from support by thousands of people and families in hundreds of communities who have benefited from the service rendered by approximately 1500 Red Cross chapters.

9. Finally, our policies are aimed at doing what is best for most of the regional programs. Naturally they produce some difficulties for those programs that face unique situations, but I doubt that any agency could function in the field of blood distribution with 100 per cent facility. The Red Cross has risen above the difficulties and helped not only the regional programs but all hospital and community blood banks. As the result of pioneering and testing procedures and technics Red Cross has brought down costs for agencies outside the Red Cross. Withal it has left to the communities served by the program freedom to determine who shall and shall not be eligible to receive the blood procured. The national headquarters and area office staffs act more in a staff and advisory rôle than in one of regimentation.—DAVID N. W. GRANT, M.D., *director, blood program, American National Red Cross.*

New York chapter. On March 10 the first mobile unit was sent to Farmingdale, L.I., in a trailer borrowed from the "Blood for Britain" program. On March 29 the first true mobile unit was sent out. Other donor centers soon opened in Philadelphia, Baltimore, Buffalo and Rochester; each of these centers shipped blood to Sharpe & Dohme for processing. By September of 1941, 15,000 packaged units of dried plasma had been procured. Then came Pearl Harbor.

The accomplishments of the American Red Cross during World War II were impressive. It procured, processed and packaged for overseas use 12,628,645 units of dried plasma and serum albumin, it provided 310,135 pints of whole blood or liquid plasma for military hospitals in the United States, and it shipped 387,462 pints of group "O" whole blood to the Pacific Theater. In the week of June 5 to 10,

1944, just following the invasion of Normandy, the maximum weekly load was reached with a record of 123,284 pints. At the height of operations there were in existence 35 centers and 63 mobile units, with approximately 53 per cent of the blood being obtained through the centers. With the cessation of hostilities, the program was closed on request of the army, and it ended officially on Sept. 15, 1945.

Concomitant with the temporary and inflated market for blood produced by armed conflict was a steady, progressive and permanent rise in civilian use. While accurate statistics on prewar and postwar blood usage are exceedingly difficult to obtain, a five to ten-fold increase would appear to be a reasonable estimate. Owing to a combination of circumstances, however, the development of community and hospital blood banks did not proceed adequately to meet these increased civilian demands. As a result, the termination of the Red Cross blood program produced an acute disparity between civilian hospital blood needs and donor procurement.

Within two years some 60 Red Cross chapters had been called upon to cooperate with local hospitals or private blood banks in an endeavor to procure donors. Early in 1947 the American Red Cross appointed a committee of private physicians to survey the needs and it was found that only approximately 20 per cent of hospitals had blood banks.

APPROVED BY ASSOCIATIONS

Because of this situation coupled with the tremendous backlog of experience gained during World War II, the American Red Cross was prevailed upon to undertake a civilian blood procurement program. This was done with approval in principle by the American Medical Association, the American Hospital Association, the American Public Health Association, the Association of State and Territorial Health Officers, the United States Public Health Service, the Veterans Administration, the army, the navy and the Division of Medical Sciences of the National Research Council. The program was actually initiated on Jan. 12, 1948, with the activation of a collection and processing center in Rochester, N.Y. Thus the controlling responsibility for civilian blood procurement passed quietly by default from the medical profession to the American Red Cross.

There can be no reasonable doubt that the institution of the American Red Cross civilian blood procurement program provided a service which at that time the majority of hospital and community blood banks were either unwilling or unable to provide. Furthermore and most unfortunately, there can be no doubt that the active and aggressive expansion of this program soon brought it into conflict with already existing hospital and community blood bank facilities and those which were rapidly becoming established.

Resolution of these conflicts at the local level was frequently impeded or rendered impossible by an atmosphere of mutual misunderstanding and recrimination. At the national level the medical societies maintained a *laissez faire* policy, while the Red Cross became increasingly rigid. The administrative situation slowly deteriorated to the point where positive action became absolutely essential to the survival of either or both programs. Owing to the intervention of the Korean War, however, such positive action was never taken.

Following the outbreak of hostilities in Korea, the Department of Defense named the American Red Cross as "the official coordinating and blood collecting agency to provide blood for immediate use and for processing into blood derivatives for the armed services." Shortly thereafter the National Security Resources Board requested the American Red Cross "to plan and coordinate a program that would provide a reserve of plasma for civil defense."

On Aug. 17, 1950, the armed services asked for whole blood. The existence of 34 regional blood centers made possible the collection of group "O" whole blood for military use. Within 72 hours approximately 1500 pints had been collected and delivered to the armed services central processing laboratory in California. This defense phase of the program was publicly announced August 21. On August 26, the first shipment left the processing laboratory for Korea.

While the relatively limited facilities of the existing Red Cross civilian blood procurement program could thus be converted for a sudden short-term increase in military requirements, they were inadequate to produce the necessary sustained volume, and it soon became obvious that the existing facilities must be expanded to meet the needs of the Department of Defense. Such expansion included development of existing regional centers, the activation of defense centers, and the inclusion of community blood banks in areas not covered by Red Cross centers.

On Dec. 1, 1950, a formal agreement was drawn up between the American Red Cross and the Department of Defense whereby the American Red Cross was to be reimbursed for actual audited costs of blood procured for defense purposes. These costs included all the technical expenses for the operation, including salaries of personnel, cost of supplies, the cost of transportation of blood from centers and cooperating blood banks to commercial processing laboratories, and for a portion of the direct administrative expenses in the collection of blood. The agreement further stipulated that the reimbursement would be on a per unit basis calculated from cost figures as determined by government audit. Expenses covering such activities as donor recruitment, publicity and promotion, canteen and other volunteer services were met by the American Red Cross. Prior to Dec. 1, 1950, the Red Cross financed the defense blood procurement, which included collection of more than 34,000 pints of group "O" whole blood by Red Cross centers and community blood banks, and the provision of 80,000 units of serum albumin that was delivered to the military establishment for emergency use.

DEVELOPED NATIONAL PROGRAM

In December of 1951, President Truman asked the director of the Office of Defense Mobilization for an integrated program for blood, blood derivatives, and related substances. A subcommittee of the Health Resources Advisory Committee was established to develop a single national blood program. Under this plan the American Red Cross remained the official coordinating and blood collecting agency. By June 30, 1952, the initial contract was completed and the American Red Cross and cooperating blood banks had delivered 3,000,000 units of blood to the Department of Defense. On July 1, 1952, under the terms of previous plans by the National Security Resources Board, a contract was negotiated by the Red Cross with the Armed Services Medical Procurement Agency to collect blood for the federal Civil Defense Administration. This contract stipulated 1,800,000 units of blood, later increased to 2,710,556. It

was subsequently modified to include an additional 258,000 units to provide albumin and gamma globulin. By June 30, 1953, the American Red Cross had in full-time operation 45 regional centers, 15 defense centers, and more than 30 subcontracting private blood banks.

As the end of the Korean War approached, it became increasingly obvious that the need for blood by the armed forces would drop precipitously and, on July 1, contracts with 15 of the more than 30 private blood banks were terminated. The Korean Armistice was signed on July 27, 1953, and on August 31 the contracts with the remaining private blood banks were terminated. In addition, all 15 defense centers were closed at the request of the government.

During the period of Korean hostilities extending from July 1, 1950, to June 30, 1953, a total of 7,727,914 pints of blood was collected by the regional centers. Of these, 3,210,685 were for the Department of Defense and 4,517,229 were for the civilian program. The national organization and chapters of the Red Cross expended an average of $6.14 per unit for each of the 7,727,914 units collected during the period under review. Owing to the terms of the contract, however, the actual reimbursement received from the government for blood collected for the Department of Defense was at the average rate of $5.68 per unit. Through the defense centers and the subcontracting private or community blood banks, 2,090,828 additional bleedings were delivered to the Department of Defense at a rate of $6.33 per unit. The cost of the 4,517,229 pints collected for civilian use plus the 46 cents per pint deficit on all blood sent to the armed forces by the regional centers was charged off against the usual charitable contributions made to the Red Cross.

Viewed in perspective, the Korean War represented a sudden, unexpected and consequently unplanned-for intrusion of military requirements into a slowly growing, peacetime blood procurement program. Its impact was great. It produced a tremendous administrative tightening which tended to subordinate the conflicts between the Red Cross and the community or hospital blood banks in the interests of a much greater joint effort; it produced considerable expansion of the Red Cross physical facilities; it provided a most powerful donor incentive, and, most important of all, it produced such a confusion of ideals, economics and statistics as to render useless any evaluation of the civilian component of the program from a normal, peacetime point of view. With this background of unsolved hostilities and artificially altered baselines, the field of civilian blood banking moved into the uneasy peace of the post-Korean War period.

The difficulties which currently exist between the American Red Cross civilian blood procurement program and the hospital and community blood banks are so diverse in nature and magnitude as to render any broad, general consideration of them almost impossible. Many are predominantly local and involve matters of logistics, unreliability of volunteer help, individual and group antagonisms, personality incompatibilities, ignorance of basic issues, and like difficulties. Others are more truly regional or national and involve matters of basic philosophy, lack of administrative flexibility, publicity policies and, above all, inability to procure blood.

While it is virtually impossible to generalize on the difficulties themselves, it is quite possible to do so with regard to their origin. It would appear that the great majority spring directly or indirectly from one or two paramount factors: One is the basic difference of philosophy between the two systems, and the other is the limited coverage provided by the American Red Cross.

The American Red Cross civilian blood procurement program is based on the philosophy that blood has a symbolic value which lifts it above economic considerations of any sort. Under no circumstance should it ever be a purchased commodity, in this view. Administration charges should be discouraged or at least disguised. Replacement to hospital blood banks

GRANT UNDERRATES ANTIPATHY: BROWN

As DR. GRANT HAS STATED, THE professional responsibilities of the Red Cross blood program are admirably discharged by professional personnel, and with this there is no quarrel. The difficulties arise when the ultimate implementation of these responsibilities becomes a function of lay personnel in the local chapter or regional centers. The intramural ignorance, conflict and even insubordination are sometimes beyond belief. Of the virtually endless examples, perhaps the most recent to come to my attention was a meeting at which the chairman of one local chapter in our state flatly declared that his chapter was completely autonomous and that he would tolerate no directives from either the director of the Massachusetts Regional Blood Program or the Massachusetts Medical Society Supervisory Committee on Blood Banks. Until the Red Cross can maintain better discipline within its own ranks, commitments among professional men at a regional or national level can have little significance.

It may well be that I have erred in vastly underrating the Red Cross program's continuing strength and growth and solidification. All things, however, are relative. I am equally convinced that Dr. Grant vastly underrates the antipathy and bitterness produced when a national organization such as the American Red Cross clothes its inadequacies in the raiments of charity and arrogantly foists them upon those who are professionally, ethically and legally responsible for the total blood needs of the hospital or community.

I should point out that in my own area the Red Cross relationships are excellent. The entire blood recruitment program is under the Red Cross and this recruiting provides for both bloodmobile and walking donor requirements. We give approximately 1000 transfusions per year and have about 3000 walking donors in our files. At present we get about 50 per cent of our blood from the Dartmouth Street Regional Center, and about 50 per cent is drawn in the hospital from walking donors. All replacements from the families and friends of patients are recruited through the Red Cross and we have not had a professional donor since the start of this program.—DONALD E. BROWN, M.D.

should be on a one-for-one basis to prevent profiteering.

In marked contradistinction, the hospital or community blood bank is based on the philosophy that blood is a biological product, like penicillin or any other commodity, and as such should be handled on economic principles. Each pint given must be either replaced or paid for and, in addition, enough extra blood or money must be taken in to compensate for the inevitable outdating. Over and above the charge for the blood, if any, there must be an administration charge to cover the cost of blood bottles, intravenous sets, nurses' salaries, and all other factors which go into its handling.

Stringent application of the Red Cross principles has caused hospital blood banks to run into debt. Overzealous application of good business principles to hospital and community blood banks has brought on charges of profiteering.

PROGRAM IS ONLY SUPPLEMENTAL

With respect to limited coverage, the Red Cross is not, nor has it ever been, anything but a partial or supplemental program. This is true from both the geographical and the percentage coverage points of view. There are currently 45 regional centers with complete coverage of four states and partial or no coverage in the remaining 44. Figures on the exact percentage coverage are difficult to arrive at but in Massachusetts, with complete geographical coverage, this approximates 50 per cent. Failure to recognize this limitation by the hospital and community blood banks has led to lack of adequate planning, inability to procure blood through the Red Cross, and resulting severe criticism. Failure to recognize its own limitations by the Red Cross has led to publicity which has misled donors and blood banks alike. In addicion, it has misled many Red Cross personnel into making official and unofficial commitments which can never be fulfilled.

In any attempt to solve these problems, it must always remain paramount that the procurement of blood is a grass roots affair. People are interested in the community nature of the endeavor with little regard for what national group sponsors it. It follows that solutions must emanate from the level at which the problems exist, with the assistance but not the interference of higher echelons. This, unfortunately, has not always been the case; frequently, directives have been passed down from area or national Red Cross headquarters, to the detriment of the local program.

Local problems are best solved by sympathetic cooperation between the hospital blood bank committee and officials of the local American Red Cross chapter. Appointment of the hospital blood bank director as chairman of the medical advisory committee to the Red Cross blood program has proved helpful. A vital factor in the establishment of an amicable working relationship is the recruitment of great numbers of local walking donors under the aegis of the Red Cross. This ends the dichotomy of recruitment which is so confusing to donors, and it provides a local source of blood which allows the hospital blood bank to be independent of the regional center if necessary. The utilization of such walking donors presupposes a blood bank equipped to bleed donors. This situation does not always obtain but should be encouraged, if only for civil defense purposes, by all regional and national agencies interested in blood procurement.

Problems at the state or regional level must be dealt with by the appropriate groups. Of inestimable aid is a strong committee of the state medical society, set up for the purpose of supervising the state Red Cross program and advising on statewide hospital and community blood bank problems.

Such a group is the Massachusetts Medical Society supervisory committee on blood banks, which meets monthly with the director of the Massachusetts Red Cross program to review current problems and consider solutions. Shortly after the end of the Korean War, this committee became impressed with the lack of valid statistics concerning blood usage in the state as a whole and instituted monthly questionnaires to some 174 participating hospital blood banks. These have been returned with a surprising degree of faithfulness and some interesting statistics have been obtained, showing that hospital blood banks procure about 50 per cent of their blood from the Red Cross regional center, and about 50 per cent from walking donors bled in the hospitals. Of the walking donors, about 10 per cent are sent in by Red Cross. Also of note is the fact that outdated blood runs about 13 to 14 per cent. Based on figures of this sort a joint policy agreement of the Massachusetts Medical Society committee and the Red Cross was drawn up to delineate clearly the rôle each agency plays in the over-all state program. The written policy is realistic and unequivocal. It allows little if any latitude for misunderstanding and the inevitable friction which results therefrom. In addition, a state plasma salvage program has been started under which outdated plasma is taken to the state laboratory, processed into albumin, and returned to the participating hospitals.

APATHY FRUSTRATES EFFORTS

Serious attempts to solve broad differences at the national level have been, until recently, frustrated by apathy on the part of the national medical organizations involved. At the time the American Red Cross instituted the civilian blood procurement program, the national societies which might reasonably have been expected to provide strong administrative control in its development were the American Medical Association, the American Society of Clinical Pathologists, and the American Hospital Association. They chose, however, to adopt a middle of the road policy of watchful waiting. This probably stemmed from the fact that blood banks were not widely represented in any of these groups and therefore it seemed unwise to commit the societies as a whole to any aggressive, active policy. Obviously some organization was needed to produce administrative and technical unity among blood bankers, and on Nov. 17, 1947, the American Association of Blood Banks was founded in Dallas, Tex. This was too late to exert any influence on the initial policies of the Red Cross blood program, which opened its first regional center a scant two months later. Over the ensuing seven years, however, the association has demonstrated remarkable expansion, to the point where it now occupies an important position among the other interested organizations, carrying tremendous weight inherent in the fact that it is composed exclusively of blood bankers and devoted solely to blood banking.

In spite of the existence of this vigorous new colleague, and in the face of rising regional, state and local conflict, the national medical organizations continued their policy of no active participation. The vital statistics so necessary to any reasonable consideration of the issues involved were un-

obtainable. Even as late as the fiscal year ending June 30, 1954, no figures were available concerning the number of blood donations made to private blood banks for civilian use throughout the country.

Finally, the absolute necessity of providing a national mechanism for the resolution of these rapidly mounting problems became obvious to all concerned, and in June 1953, the house of delegates of the American Medical Association passed the so-called Ludwig Resolution. This called for "the establishment of a coordinated national blood program operated by the American Medical Association, the American National Red Cross, and other qualified organizations interested in blood banking, on the following basis: (1) Medical aspects of blood banking shall be under the exclusive control of the medical profession; (2) business administration, donor recruitment, stock piling for civil defense and disaster relief, allocation of supplies to meet military needs, and public relations shall be matters of joint concern; (3) the supply of blood shall be maintained on a replacement basis; (4) the national blood program shall be a financially self-supporting but nonprofit arrangement operated in the national interest but with the sole aim of promoting the widest availability of safe, usable blood and its derivatives."

BLOOD FOUNDATION ORGANIZED

The original resolution has now been developed into a blood foundation including representation from the American Association of Blood Banks, the American Hospital Association, the American Medical Association, the American National Red Cross, and the American Society of Clinical Pathologists. After many meetings, however, the basic issue of whether the foundation should be a coordinating and policy making body or an operative and regulating body had not yet been fully settled. It is the feeling of the American Association of Blood Banks that the plan "could and should be handled initially by a small, deliberative group rather than by the much more expensive group visualized in the plan of May 29, 1954." Should the efforts of such a policy making body fail after a reasonable period, then a stronger, relatively independent new operating organization might be indicated, the association has acknowledged.

Obviously the successful operation of the blood foundation is of prime interest to all who are concerned with the running of a community or hospital blood bank. Such an organization is highly desirable for those who enjoy strong local, state and regional organizations, and it is an absolute necessity for those whose sole recourse is through the national organizations. If, in addition, the present trend of the federal government away from centralization should be reversed at any time, such a foundation, made up of its present professional groups, would be a *sine qua non* for any vestige of independence at the local level.

Probably the most significant development to date in this complex panorama has been the recent recognition and public admission by the Red Cross that the collecting and processing of blood for civilian use costs money and that the usual charitable contributions have been inadequate to meet this cost. As a result, in many areas the community and hospital blood banks have been asked to underwrite the expense on a per pint percentage basis. The exact percentage is a function of the total cost, the number of pints collected, and the charitable contributions available. The figure is therefore variable, but at present it approximates 50 per cent of the per pint cost. Superimposed on this basic change in policy is an increasing shift of financial responsibility from the national to the local level.

In the past, the national organization has supplied about 70 per cent of the money, and about 30 per cent has been supplied locally. It is estimated that by 1957 this will be completely reversed, with approximately 30 per cent coming from the national headquarters and some 70 per cent coming from local chapters. This will involve predominantly those chapters which are active in the blood procurement program. Lack of appreciable support from chapters not conducting blood programs will thus throw an even greater burden on those which are engaged in blood procurement.

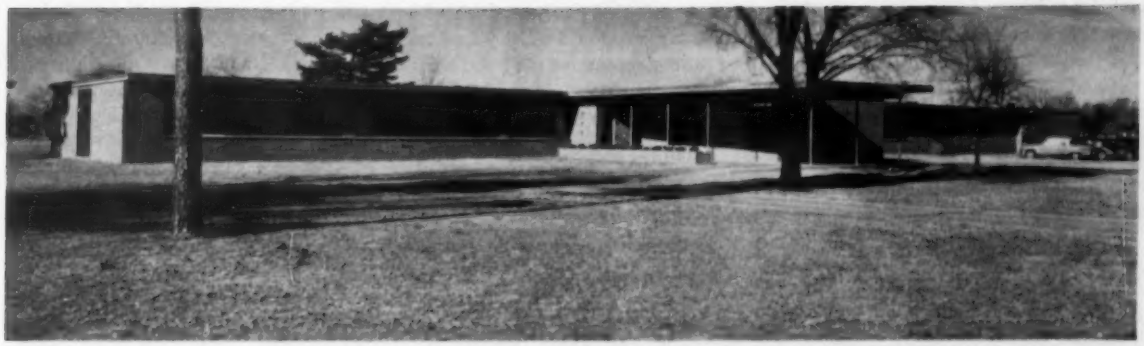
The introduction of financial transactions into the Red Cross program contributes a major item of conflict in an already controversial area. It strikes deeply at the heart of Red Cross philosophy by demonstrating to all that there is no such thing as free blood. It weakens the Red Cross stand against "pay-as-you-go" economics in community and hospital blood banks. It strengthens the position of community and hospital blood banks at all levels, for if they are partially to underwrite the cost, they should assuredly exercise proportionate control.

In areas of partial Red Cross coverage, the new financial arrangement means an end to disproportionate distribution, for no hospital or geographical area can afford to underwrite another economically. It poses problems of insurance coverage and integration with already existing administration charges. Above all, it introduces a tremendous element of uncertainty in donor recruitment. No matter how carefully the situation is presented, the concept that the charge is directly for the blood is difficult to dispel. If donor recruitment falls off, the underwriting cost per pint increases, and eventually approaches the cost per pint in the community or hospital blood bank. When and if this occurs, the majority of blood bankers are likely to feel that the advantages of the Red Cross program do not outweigh the disadvantages. At this point the Red Cross program will collapse—not from above downward, but from the bottom up. In the final analysis, blood banking is basically an affair concerning the donor, the local blood bank, and the recipient.

MUST RECOGNIZE PROBLEMS

In summary, it must be clearly recognized that difficult problems exist and that their solution depends upon good will, understanding and compromise. Community and hospital blood banks must carefully consider the Red Cross program with respect to its backlog of experience, its administrative organization, its physical equipment, and its army of volunteers and free publicity which enable it currently to collect blood more economically than the majority of private banks ($5.32 per pint). The Red Cross must carefully consider its secondary or supplemental rôle in civilian blood procurement, its difficulties in maintaining intramural discipline, the antagonism which many of its policies and actions have generated, and its current financial situation.

There is no doubt that all these problems can be solved, for in many areas they have been, with results that are truly inspiring. It is the solemn obligation of all concerned squarely to face these existing difficulties, and to resolve them in a just, realistic and forthright fashion.



Front elevation of the new Memorial Hospital of Schuyler, Neb. Because most of the flow of the Platte River, on which the town is located, is underground, it was necessary to place facilities ordinarily found in the basement, except for the boiler room, on a level with the rest of the building.

THE MODERN HOSPITAL OF THE MONTH

Solution to a site problem:

They Brought the Basement Upstairs

ELLERY M. DAVIS

Davis and Wilson, Architects and Engineers
Lincoln, Neb.

OUTLINE OF CONSTRUCTION COSTS

Number of beds	34	
Additional beds planned	12	
Construction cost (including Group I equipment)		$346,909.57
Cost per bed (@34 beds)		10,203.00
Total square feet	17,150	
Square feet per bed	504	
Total cubic feet	265,825	
Cubic feet per bed	7,815	
Cost per square foot		$ 20.23
Cost per cubic foot		$ 1.30

As patients and visitors enter the hospital they are greeted by the receptionist standing behind a streamlined counter, with the general office beyond it. Colorful draperies lend a cheerful effect to this area.



THE Platte River, on whose banks the city of Schuyler, Neb., is located, is like the stream in Arizona which the Indians call "Hassayampa," meaning "the river which flows upside down." It has a wide, flat valley and most of the flow is underground. Throughout the valley ground water is usually found at 8 feet and frequently during rainy seasons rises to within 4 feet of the surface. For this reason, the people of Schuyler were reluctant to provide a deep basement under their new community hospital building.

The alternatives to a basement deep in the ground were either to raise the first floor of the building some 5 or 6 feet above grade, or to dispense with the basement entirely and place such facilities as would ordinarily be found in the basement on the same level as the remainder of the building. The latter course was finally adopted and everybody concerned has been pleased with the result. All facilities in the building, except the boiler room, have been placed upon one floor level which is approximately the same as that of the finish grade around the building. The boiler room floor is 4 feet below the main floor to permit steam return piping to have proper fall and to gain

added headroom for equipment. The entire area underneath the main floor, however, has been excavated to an elevation even with the bottom of the exterior wall footings and this provides an open walk space, which is very convenient for inspecting and maintaining the many different kinds of piping which are necessary in a hospital building. The walk space is approximately 6 feet high in the clear at the center and slopes upward to a clearance of approximately 4 feet at the outside walls.

The city of Schuyler is a county seat town of approximately 3500 people located in the center of Colfax County which has a total population of 10,158. The new hospital has been financed by public subscription with the assistance of a 50 per cent grant from the federal government through the Hill-Burton Act. Prior to its construction, it was necessary for the community to go to Columbus for hospitalization, a distance of 17 miles, or to Fremont, a distance of 37 miles.

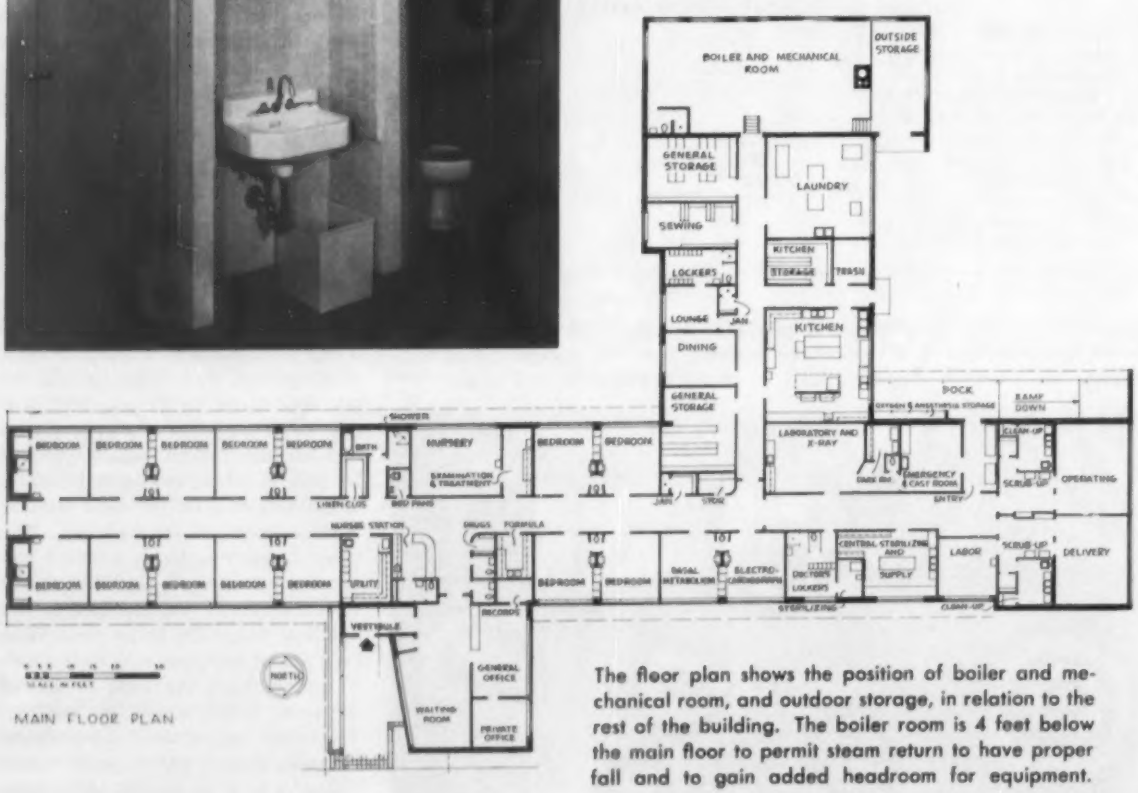
The building contains 16 patients' rooms, each large enough for two beds, plus a labor room, also sized for two beds. It offers facilities for surgical, medical and maternity patients. It is completely air-conditioned the year-round, there being a central system of mechanical forced air ventilation providing fresh tempered air in winter and fresh cooled and dehumidified air in the summer. This feature is rapidly becoming an important drawing card for community hospitals because of the rigorous Nebraska climate.

The heating system is hot water, furnished by a gas-fired hot water boiler serving continuous fin tube convector radiators. Sterilizers and laundry and kitchen equipment are served by a separate small high-pressure steam generator. Shortly after the hospital was put into operation, a second high-pressure steam generator was purchased and installed in order to provide standby for this important service.

A central oxygen supply system has been installed serving the patients' rooms generally, the nursery, and the operating rooms. A feature of this installation which may be of interest to administrators is the location of an outside oxygen and anesthesia cylinder storage area on a dock in the service court of the building. It is located under roof on the dock and the cylinders are protected by steel mesh doors. This removes the explosion hazard from the inside of the building and also is convenient for replacement of cylinders.



Left: Bedroom storage wall provides space for patients' clothes and suitcases, below, and blankets and pillows, above. Each room has separate lavatory and toilet.



The floor plan shows the position of boiler and mechanical room, and outdoor storage, in relation to the rest of the building. The boiler room is 4 feet below the main floor to permit steam return to have proper fall and to gain added headroom for equipment.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Certificates have been presented to the hospital, architects and state officials. A similar award will be made by The Modern Hospital each month.





Above: Typical bedroom. Rooms are bright and cheerful, with windows that extend from wall to wall. The rooms are designed to eliminate the necessity for dresser or bureau. Below: A glass partition protects part of the nurses' station from view of patients and visitors.

Another feature of the building is the use of plastic dome skylights on the roofs above interior areas, such as service corridors, scrub-up rooms, and particularly above the nurses' station.

Recognition has been given to the fact that approach to this building will be by automobile and the entrance porch roof has been extended to form a porte-cochere over the entrance drive so that visitors and patients can be disembarked under roof before the automobile proceeds to the parking area near by. There are no steps for visitors to climb while entering the building.

The typical bedroom has been planned of sufficient size to accommodate two beds. Each bedroom has a separate lavatory in a tiled recess. A water closet has been placed in a separate cubicle between each pair of bedrooms. Two built-in hardwood storage cabinets have been provided in each room and designed so that each patient can store his street clothes and suitcase therein. Additional storage has also been provided for blankets and pillows above the patients' clothing storage area. The rooms have been designed so as to eliminate the necessity for a dresser or bureau as a piece of movable furniture. The windows in all bedrooms extend continuously from wall to wall, with a large fixed glass in the center flanked by smaller panels which can be opened.

The construction is completely fire resistive. Exterior walls are of face brick backed up with concrete block

masonry units. All exterior walls are furred and insulated. Interior walls and partitions are of steel studs with metal lath and gypsum plaster. Main floor construction consists of steel bar joists resting on steel columns and beams with reinforced concrete floor slab. Roof construction consists of steel bar joists resting on steel columns and beams and steel deck. Ceilings generally are suspended and are constructed of steel channels, metal lath, and gypsum plaster. Acoustical tiles have been applied to the plaster ceiling surfaces in areas in which noise reduction is important.

Hospital Officials Comment on the Plan

THE building committee of Schuyler Memorial Hospital selected the hospital plan as submitted by the architectural firm of Davis and Wilson for the following reasons:

The one-floor plan permits more efficient staffing and management.

There is good segregation of the various departments. Surgery, delivery and emergency suites are completely separated.

The rooms all being above grade have the advantage of simple construction and economy.

Such design will permit future expansion without the necessity of complete remodeling. — RICHARD F. HRABAK, *chairman, building committee.*

I WOULD like to review the departments one at a time, and as the boiler room is perhaps the most important from an operational standpoint, I will start there. Our air conditioning system and heating have functioned very well and, though all new buildings have some "bugs" to be worked out, we feel we have had little trouble with these, with the exception of the water drainage. This is going to present a problem because of the flat level we are on here. This will be corrected, however, with the addition of a storage tank next summer, if it can be worked out with the health department.

Our heating boiler has given no trouble whatsoever. I would like to suggest a future consideration of a stand-by boiler unit for high pressure steam or a different setup to provide hot water for the building. In a small hospital it is impossible to give the boilers the attention they perhaps deserve owing to the high cost of providing a maintenance man in the night time. However, with all the safety devices and an additional boiler, I feel this is not needed and thereby cuts the cost of operation.

Our laundry is the next department in the service wing, and is in every way fine but is not large enough. This condition is not the result of any error but it is impossible to foresee what activity some departments will have. I continue to be amazed that these hospitals are constructed in communities that have never had one and still are sufficient for community needs without waste space and errors as it is so hard to foresee the patient load. Certainly, the architectural profession and state and government agencies are to be congratulated.

The kitchen, which is next in line, is meeting our needs. The fact that it has a north view is an outstanding example of foresight. The people who staff these departments are generally in the middle age bracket and too much glare from the east or west is certainly disconcerting.

The floor in the area being of asphalt tile is hard to maintain but, there also, another type might present a problem. The storage we have is sufficient.

The surgical suite, which includes surgery, laboratory and darkroom, O.B. and central supply, leaves little to be desired. We are adding one lavatory stool in one of the small storerooms off the labor room.

The patient rooms are complete in every detail. They are bright and cheerful and the personnel enjoys working in this modern hospital. Outstanding features in the hospital are the plastic skylights which give added light, and the large wall to wall windows.— FRED C. MILDREXLER, *administrator, Memorial Hospital, Schuyler, Neb.*

Interior and exterior door frames are of steel. Doors are wood, of hollow core flush slab design. The entire roof area is insulated with 1 inch thickness of rigid insulation board built into the roofing which is of 20 year bonded coal tar-pitch and gravel type. The roof is dead level and is constructed so as to carry an inch of water during the air conditioning season. This will provide the benefits of evaporative cooling and decrease the load on the air conditioning compressor. Water discharge from the air conditioning system is piped to the roof and ferrules are placed in the roof drains so as to allow water to accumulate on the roof to a depth of 1 inch before overflowing into the drains.

FLOORS ARE ASPHALT TILE

Floor covering generally throughout the building consists of asphalt tile in various colors and patterns with coved rubber base. In each bedroom, a hardwood sloping base has been especially detailed which holds the casters of the beds away from the wall and prevents marring of the wall surface.

Finish floors in so-called "hazardous" areas, such as operating, delivery room, x-ray, emergency and scrub-up rooms, are of conductive terrazzo. All interior window sills throughout the building are of quarry tile. Glazed ceramic tile wainscot has been provided in operating and delivery rooms and around all lavatories throughout.

Because of the horizontal development of the plan, it was considered necessary to divide the building into three portions by means of expansion joints which cut entirely through the roof, floor and walls. These joints separate the building, which is a "T" shaped plan, into three separate rectangles of nearly equal areas.

An important feature of the building is the 4 foot roof overhang along the east and west sides shading the bedroom windows. The overhang materially reduces the sun effect on the glass and has resulted in economies of operation and first cost on the air conditioning system.

Another feature of the building, especially from the point of view of the custodian, is the storage area at the end of the boiler room with the floor set at grade level and giving directly onto the service court with a pair of large doors. This area is very convenient for the storage of garden hose, lawn mowers, and for parking the motorized snow plow.



William L. Wilson (left), retiring president of the New England Hospital Assembly, and Richard T. Viguers, incoming president and program chairman of the meeting, set out instructional conference cards at the Statler Hotel.

Something new and different in hospital meetings are the instructional conferences for small groups pioneered by the New England Hospital Assembly

EDWARD M. FRIEDLANDER
Director of Public Relations
New England Center Hospital
Boston

New England Meeting Gets Down to Cases

THE pioneer efforts of the New England Hospital Assembly in introducing what its leaders called "Instructional Conferences" into its 32d annual meeting at the Hotel Statler in Boston March 28 to 30 met with overwhelming success. They stand as a lesson which all those concerned with hospitals and the education of their personnel might well examine. With a total registration at the 1955 assembly reaching nearly 6000, its success this year was multiplied by this well accepted innovation into area hospital meetings.

Since it was an experiment, the conferences were planned modestly as an addition to the assembly, but attracted an overwhelming response. The 27 sessions scheduled for a maximum enrollment of 25 students per session for a total of 675 found the undreamed of number of 2849 applications for the 675 seats.

Was this innovation as successful as these figures might indicate? What led to the original idea? How was it handled? These were questions assembly registrants asked during and following the assembly and questions that other hospital groups will want to have answered.

Following the 1954 meeting, the

Pearl R. Fisher, R.N., of Waterville, Maine, welcomes her "students" at the instructional conference on the "Nursing Audit," which was held twice during the three-day session.



Frank E. Parkin, controller of New England Center Hospital, Boston, outlines his course in "Building a Hospital Budget," which attracted administrators, accountants, bookkeepers.



New England Hospital Assembly officers and trustees faced the problem of providing the 1955 registrants with sessions that would not overflow into the corridors of the Hotel Statler, Boston's largest convention center, and at the same time would meet the need of expanding the program to fulfill an increasing number of requests for a broader program of topics of interest and education in specialized hospital fields.

Dr. Frederick T. Hill, medical director of the Thayer Hospital in Waterville, Maine, and 1954 president of the assembly, introduced the idea of the instructional conferences. It was considered and accepted as one effective approach to fulfilling the recognized needs. With the idea of making the assembly a teaching institute as well as an educational meeting, the conferences were outlined to include subjects covering as much of the entire spectrum of hospital personnel as time and space limitations would allow.

The plan was based on Dr. Hill's experience with the success of a similar institute created by the American Academy of Ophthalmology and Otolaryngology, now in its 15th year and finding greater and greater success in small meetings covering specific subjects for its membership.

"As a living, dynamic postgraduate course on specific subjects in accordance with the effective modern idea of a low faculty-student ratio, considered good academic procedure, the annual meeting of our academy found a new means to help its members," said Dr. Hill in explaining his reason for the suggestion to the assembly. "Today the academy has its own instructional equipment, a faculty of qualified instructors, and an eager group of specialists who look forward to the annual meeting as a program from which they can take home specific knowledge otherwise difficult, if not impossible, to achieve."

With the acceptance of Dr. Hill's suggestion, the job of translating the idea into reality fell to Richard T. Viguers, administrator of the New England Medical Center's New England Center Hospital, president-elect of the assembly, and program chairman for 1955. Topics, instructors and format were considered.

"A subject would only be as good as its instructor, and a good instructor with an unattractive, unimportant and untimely subject would be disastrous to our hope for a successful experiment in expanding the objectives of the assembly," said Mr. Viguers. "In order to try to give those who might enroll in the courses something concrete and beneficial, we had to achieve as effective a combination of the two as possible."

Mr. Viguers, together with the program committee, followed this credo with care. Topics which had long gone wanting full discussion were plentiful and the men and women invited as instructors were quick in their acceptance. They too were fascinated with the new idea. On Feb. 9, 1955, the first brochure announcing the new program was mailed to the 437 member hospitals in the New England area. By February 18, 300 reservations had been received. A week later the total was 931. By assembly time it had soared to 2849. Refunds together with regrets had to be sent out, but in an effort to accommodate the largest possible number of applications in the space and time available, the maximum number in each session was increased to 40 and 50, and nine "repeat courses" were added.

No course lacked applicants. Every one was oversubscribed. "Supervision —the Department Head's Job" attracted 254 applications. "The Nursing Audit" attracted 156; "Personnel Policies," 137; "How to Run a Department Head Meeting," 122, and on through the 27 courses which included a wide range of topics such as "Organizing the Administrator—for Secretaries Only," "Successful Collection Methods," "Approaches to Fund Raising," "Hospital Accreditation," and others. Each was designed to give one specialized group something of particular interest and information to them.

When the assembly opened on March 28, all eyes were on the new program. Fears that the conferences would deplete attendance at the general sessions were never realized. Those sessions attracted the same capacity audiences they always did. Concern that the conferences would not live up to expectations swiftly disappeared as student after student was quick to comment on the value of the material presented. Instructors who at first wondered about the interest of their audiences were thrilled to discover their groups anxious to learn and ready to ply them with questions.

The conferences, although designed primarily for specific types of hospital personnel, attracted a cross section of representatives. The session on fund raising, for example, drew not only administrators, but public relations directors, hospital trustees and volunteers, and even professional fund raisers from large nationally recognized organizations. The nursing audit brought not only nurses into the session, but administrators and

(*Continued on Page* 168)

Sister Annunciata and Sister Mary Mercy, Mercy Hospital, Portland, Maine, buy tickets for instructional conference. Watching (l. to r.) are Lois Bliss, association treasurer; William L. Wilson; Mrs. Paul Stanton, secretary, Massachusetts Hospital Association, and Exhibit Manager William S. Brines, director of Newton-Wellesley Hospital, Newton Lower Falls, Mass.



Memo to central supply supervisors:

Selection Is the Key to Economy

DEWEY H. PALMER
New York City

CENTRAL supply handles and consumes large quantities of materials used in the most important area of the hospital, the operating room. Economy of operation depends on selecting types of materials best suited for the end use, and on proper reconditioning and sterilization.

Textiles represent a majority of the items processed in central supply. Because of frequent laundering and sterilization, the life of these materials is greatly shortened. It has been estimated that deterioration owing to actual use amounts to only 10 per cent, while the remaining 90 per cent of the loss of life of these materials is about equally divided between laundering and sterilization. For example, it is estimated that an ordinary bed sheet will last from three to three and one-half years, or for 100 to 150 weekly launderings, while sheeting used in the sterilizing room will last only one-half that time, or about 50 to 75 cycles.

TYPES OF MATERIALS USED

A wide variety of cotton textile fabrics is regularly sterilized in central supply. Special fabrics are used for sterilizing packs, operating gowns, laparotomy sheets and drapes, and so on. Unfortunately, from the standpoint of economy, little information is available about the relative durability of these fabrics in terms of their end use.

A series of carefully controlled service tests would undoubtedly disclose that certain fabrics were much more durable to repeated laundering and sterilization than others are. Such a study would enable hospitals to select the fabrics which give them maximum durability for a particular end use.

Sheetings of various weights and types are the commonest textile items processed in central supply. Of the many types of sheetings, Type 140 is probably used in greatest quantity. This type has an approximate thread count of 68 in the warp and 72 in the fill, and is covered in A.S.A. Standard L4.1-1948. Another type of sheeting is the 128, also covered in the A.S.A. Standard.

(*Continued on Page 64*)

Table 1—A.S.A. Standard L4.1-1948

Sheetings	Breaking Strength (Lbs.) Warp	Fill	Maximum Added Sizing	Minimum Weight (oz./sq. yd.)
Type 140 (72x68)	70	70	4%	4.6
Type 128 (64x64)	55	55	6%	4.0

Table 2—Results of Tests of Linene Fabric

Fabric	Thread Count Warp	Fill	Wt./Sq. Yd. (Oz.)	Breaking Strength (Lbs.) Warp	Fill	Shrinkage Warp	Fill
Linene 1	54.0	47.0	4.9	58.4	46.0	8.40	0.0
Linene 2	54.0	45.0	5.3	56.3	46.7	4.0	0.50
Brand A	54.0	47.0	5.2	65.2	71.4	0.55	0.4 (stretch)
Brand B	53.5	56.0	5.4	68.8	78.2	1.75	1.6

Table 3—Characteristics of Fabrics Studied at the University of Minnesota

Fabric	Thread Count Warp	Fill	Wt./Sq. Yd. (Oz.)	Breaking Strength (Lbs.) Warp	Fill
Poplin	108.9	50.1	4.63	115.90	48.10
Jean	101.1	62.5	5.49	83.85	54.70
Broadcloth	157.8	77.5	3.43	65.30	36.90
Suiting (Linene)	52.4	48.6	5.50	64.65	67.65

Table 4—Breaking Strength

Fabric	Breaking Strength (Lbs.) Warp	Fill
Poplin	65.53	37.29
Jean	38.16	33.55
Broadcloth	19.71	14.60
Suiting (Linene)	28.96	28.65

This article is based on a paper presented to an Institute of Central Sterile Supply Room Administration of the American Hospital Association, Atlantic City, N.J. Mr. Palmer is a lecturer on standards of quality for institutional supplies in the School of General Studies, Columbia University.

Twills are used in large quantities in many institutions; in fact, some hospitals use more twills than regular muslin sheeting. The different types of twill are designated by yards per pound. One of the commonest types runs 2.85 yards per pound, 36 inches wide, thread count 96 by 64. The federal specification requires a minimum breaking strength of 85 pounds in the warp and 48 pounds in the fill.

Several different kinds of Linenes are used for nurses' and doctors' gowns. Tests have been made of several classes of these Linene fabrics, and the results are shown in Table 2.

Not many studies have been made on the wearability of the different kinds of fabrics; however, one interesting investigation has been made by the department of home economics of the University of Minnesota. Several fabrics were used, the initial characteristics of which are shown in Table 3 on page 63.

These materials were made into nurses' uniforms which were kept in service until they were worn out. Deterioration of the fabrics owing to wear and laundering was determined by laboratory tests for breaking strength, bursting strength, loss in weight, and elongation. Visual evidence of wear was recorded under three main groups: scorches and stains, wear or tears on the skirt, wear or tears on the blouse. Evidence of loss of strength after 60 days of wear and laundering is shown by the figures for breaking strength in Table 4.

After 60 days the suiting had the lowest bursting strength of any of the fabrics. Despite the fact that this material was one of the heaviest and thickest of the four tested, it was found to be the least durable.

Although poplin was comparatively light, it showed superior serviceability from both the standpoint of visual evidence of wear and the physical properties that were measured.

Jean was second in durability, while broadcloth averaged only slightly better than the suiting or Linene.

We need to have more studies of this kind made on all types of fabrics suitable for operating room use. By careful service tests of different kinds of Linenes, sheetings, twills and drills, we could establish the most durable type of fabric for uniforms, drapes, sterilizing pack covers, and the many special textile items handled by central supply. Such a study would result in savings of hundreds of dollars each year for even the medium and small sized institutions.

Most supervisors know that unbleached cotton goods are stronger and more durable than bleached goods of the same construction. Tests show that unbleached sheeting is about 10 to 15 per cent stronger than bleached sheeting of the same construction. Unbleached sheeting should, therefore, be used where it can be adopted without the need of considering appearance.

TEXTILE LIFE

It is generally known that excessively high temperatures and overlong sterilization destroy cotton fabrics rapidly. It is essential, of course, that all cotton items going into the operating room be sterilized, but the minimum safe procedures established should be followed closely and bundles should not be left in the sterilizer after the prescribed period. In addition to this, the sterilizer controls should be checked regularly to be certain that temperatures are correct, and that they are neither higher nor lower than required.

Competition with man-made fibers is leading the cotton industry to speed up its research for improving cotton fabrics. The U.S. Department of Agriculture, for example, has developed an acetylated cotton which tests show to be much more resistant to heat than regular cotton is. There is also evidence that such treated cotton would last much longer for sterilizing packs than the materials now being used. Other treatments for cotton fabrics have been developed in Europe which promise to extend their life even longer —as much as 10 times—according to the manufacturer.

Before leaving this subject of cotton, we should mention surgical dressings. Most central supply supervisors are familiar with the standard surgical dressings, particularly the all-gauze and cotton-filmated gauze sponges. We have seen in recent months efforts to produce less expensive materials for top dressings, some of which have not been satisfactory. Some of these attempts include the use of sheets of cellulose in place of cotton as the absorbency medium. We know little or nothing about the purity of these items since they are not covered by United States Pharmacopoeia standards. Neither do we know much about the effect of heat upon them. High sterilization temperatures would undoubtedly reduce the absorbency of such cellulose filler. We need to know more about these developments—how they stand up in actual hospital procedures.

PAPER WRAPPERS

The value of disposable paper wrappers as containers for sterile supply dressings is recognized by all. In fact, paper has been introduced at a phenomenal rate. Some of the sterilizer manufacturers appeared to oppose this development originally, but are now themselves selling paper bags and envelopes for this purpose.

Paper has been widely adopted without much consideration being given to several important factors such as steam penetration, air permeability, wet strength, and resistance to micro-organisms. Fortunately, a rather exhaustive study has been made recently and reported in the September-October 1953 *Bulletin* of the American Society of Hospital Pharmacists by Messrs. Beck, Shay and Purdum. Every supervisor of central supply should read this study carefully. Out of 55 samples of paper which were tested, 17 were found to be worthless because they could not withstand autoclaving. Only 16 samples out of the total were found to be acceptable in every respect. The most acceptable type of paper disclosed by this test was the kraft type. Not only was this found to be satisfactory in every utility characteristic, but it was the least expensive.

The office of the army surgeon general has informed me that it has standardized on brown 40 pound kraft paper. Standard cut sizes have been established ranging from 2½ by 2½ inches to 36 by 36 inches. The Veterans Administration has standardized on similar sizes but of a more expensive parchment paper of a 27 pound basis weight treated with glycerine to bring it up to 31 pounds. This paper is strong and capable of withstanding moisture, grease, hot live steam, and boiling. It is covered by Federal Specification UU-P-31. The Armed Services Medical Procurement Agency has standardized on a parchment paper identical with this.

RUBBER GLOVES

The greatest cause of deterioration of rubber is exposure to sunlight, heat, oils, greases and petroleum solvents. If left exposed to sunlight and air, rubber will quickly harden and crack. High heat will accelerate this process, particularly when air or oxygen is present.

(*Continued on Page* 146)



Reception room of the Mather Home in Evanston, Ill.

Experts analyze

Nursing Homes: Present and Future

In discussions ranging from philosophy to fire escapes, leaders in the field of long-term care turn the nursing home of the present inside out to determine how the nursing home of the future can be designed and administered to meet the rising demand for better care of the aged and the chronically ill

A Nursing Home by Any Name Page 66
Edna E. Nicholson

Survey Shows How Services Vary Page 67
Jerry Solon and Dean W. Roberts, M.D.

Color Puts the "Home" in Nursing Home Page 75
Raymond P. Sloan

The Best Homes Work With Hospitals Page 78
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Design for Care of the Chronically Ill Page 79
Division of Hospital Facilities, P.H.S.

Booby Traps in the Blueprints Page 80
Isaiah Ehrlich

Five Steps to Fire Safety Page 85
Julian Smariga

Sprinklers Are a Liquid Asset Page 87
George E. Linney

A Nursing Home by Any Name—

may be a nursing home or it may not. Here are some of the ways to determine whether nursing homes — so-called — come within the true definition of the term

EDNA E. NICHOLSON
Executive Director
The Institute of Medicine, Chicago

TWO types of institutional facilities are required to meet the needs of persons with chronic diseases:

1. Hospitals, whose primary purpose is diagnosis and treatment and which accept patients for limited periods of time while they can profit from these specialized services.

2. Homes, whose primary purpose is to provide for the patient a good substitute for a home of his own, including the security of being able to remain indefinitely and to receive such medical supervision, nursing care, and other services as he needs and as he might reasonably expect to receive in his own home if he had a good home and a family able and willing to care for him there.

There are, of course, many variations within both of these classifications. It usually is possible to draw a reasonably clear line of distinction between the two categories, however, on the basis of whether their primary purpose is diagnosis and treatment or continued routine care, and whether they offer a home for the patient for however long he may require it or care for him only temporarily while he is receiving active treatment.

Although practically all the facilities currently in operation can be classified under one or the other of these titles, they are not all known by these names at the present time, nor do all of them regard themselves as "homes" or "hospitals" in accordance with this classification. This is true particularly of some places described as "hospitals for the chronically ill" although under this classification they would be described as homes offering long-term care.

In some cases, so-called chronic disease hospitals were planned and equipped as hospitals for diagnosis and treatment and have attempted to operate as such but have found in actual experience that their beds are filled by patients needing long-term care and they are, in fact, functioning as homes. In other instances, the facilities have been established and are operating as homes but have adopted the title of "hospital," because it is thought to have greater public appeal. Some institutions are described as hospitals because their patients predominantly are bedridden while the term "home" is reserved for places serving chiefly ambulant people. Of course, it is entirely possible for a hospital and a home to be operated as integral parts of the same institution.

Condensed from chapters IV and V of a forthcoming book on facilities for the aged to be published by G. P. Putnam's Sons, New York.

NURSING HOMES

In common usage in the United States, the term "nursing home" has come to mean a small, privately owned place for the care of people who need personal attention and nursing service but no longer require the diagnostic and treatment facilities of a general hospital and, for one reason or another, cannot or prefer not to be cared for in their own homes. There is no reason, however, why the term should be applied only to privately owned facilities. Under the ownership and management of a voluntary nonprofit corporation, a governmental unit, or one or more private individuals, the facilities are essentially the same if persons residing in them have the same requirements and need the same services.

At the present time, people with virtually the same characteristics and requirements are found receiving care in facilities operating under many different names: homes for the aged, nursing homes, rest homes, convalescent homes, boarding homes, guest houses, city or county infirmaries, hospitals for the chronically ill, and others. All of them are facilities for long-term care of people who require a home with personal attention and nursing care and all of them might be described quite accurately as nursing homes.

The need for more beds in facilities of this kind is well known. It is being felt in almost every community and this is the aspect of the problem of chronic illness which is causing immediate and intense pressure for action. There are few, if any, communities where there is not urgent need for more and better institutional facilities for long-term care.

How should long-term care be provided? There are many

(*Continued on Page 68*)

NURSING HOME COSTS

The argument commonly used against inclusion of units for long-term care as integral parts of general hospital service is a financial one. At the present time operating costs in general hospitals are much higher than are those in most of the facilities offering long-term care. This fact has been cited as indicating that it will cost more to operate units for long-term care attached to general hospitals than it does to operate them independently.

An examination of the facts, however, shows that this is not true or, at least, that it is not true *if good care is provided in the long-term units.* Currently, the quality of care being provided in good hospitals is generally high while the quality of care being offered in most long-term facilities is so low that communities everywhere are demanding sweeping improvements. Obviously, a high quality of service is more expensive than is inadequate care. As improvements are made in the quality of care in long-term facilities, costs inevitably rise and the gap between costs in general hospitals and those in units for long-term care narrows. These improvements in the care of infirm and chronically ill people are long overdue. They are coming rapidly now, the demand for them is strong, and the widely held belief that second or third class care is good enough for the chronically ill is giving way to more enlightened opinion. Experience in the few places in the United States where a really good quality of long-term care has been provided over a substantial period of time indicates that when satisfactory long-term care is given its cost is about two-thirds that of providing general hospital care in the same area.

This brings us to consideration of another danger in comparing current per diem costs in general hospitals with those in facilities for long-term care. The services covered by the costs are not comparable. The function of the general hospital is to provide diagnosis and treatment. It is always more expensive to provide these services than it is to give long-term care. This is true regardless of where the two types of service are given. If the general hospital maintains a unit for long-term care and operates it on the same standards and with the same efficiency it will find that the per diem costs in the long-term unit consistently average approximately two-thirds of the per diem costs in the units for diagnosis and treatment.

Survey Shows How Services Vary

Progress report on a 13 state study of the types of care offered in private nursing homes

JERRY SOLON and DEAN W. ROBERTS, M.D.

IN THE perspective of our knowledge about other medical care services, very little is known about nursing homes. The lack of information in this area does more than merely leave our interest unsatisfied. It reflects on the very utilization of nursing homes and on their rôle and relationships in the whole complex of medical care. As long as nursing homes remain something remote and unfamiliar to medical practitioners, to hospitals, and to the general public, they will fail to be engaged up to their full potential, with respect to both quantity and quality.

Concern with the lack of information about nursing homes, together with recognition of the important part they must play in care of chronically ill patients, led the Commission on Chronic Illness and the Public Health Service to join forces in a fact-finding study. Many questions needed answering: What kind of facility is the nursing home? What kinds of patients does it care for? What level of illness and disability is represented? What services do patients receive? How close is the medical supervision?

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SURVEY COVERAGE

A particular approach to answering these questions was taken, namely, to obtain information about the individual patients and their care in these establishments. The character of existing nursing homes would be realistically observed by seeing what types of people they accommodate and what types of services they provide to them.

Forms and procedures for carrying through this type of study were developed in a pilot survey conducted in Maryland. The resultant methodology was then made available to state agencies which evinced interest in conducting such a survey. The end object for the Commission on Chronic Illness and the Public Health Service is to project a national picture from the data of the surveying states.

In all, 13 states are participating in the survey. By a combination of good fortune and some solicitation, these states are widely scattered across the nation and include representation of most of the "kinds" of states that might conceivably have a different pattern of nursing home care. The nature and extent of differences in findings among the study states will in part determine the reliability with which national inferences may be drawn.

Derivation of national data and a thorough analysis of the survey results cannot be undertaken until the findings of all of the study states become available. This interim report is being published at this time, however, because of the current widespread interest in nursing homes. It presents selected data on proprietary nursing homes for

(*Continued From Page 66*)

ways in which it is possible to provide long-term care for chronically ill people. Some have proved their usefulness and some stand out as painful examples of what should not be done. It may be assumed that the method of choice is the one that will give the best care to the patients, economically and efficiently, and will function smoothly as a part of the total community program for care of the sick. Good care for patients must be accessible and easily used to meet the needs of the patient promptly; it must be comprehensive, including all of the specialized services and equipment necessary to meet the requirements of the patients; the services must be provided by competent personnel and be of good quality, and there must be continuity throughout all of the care the patient receives.

Accomplishing these objectives requires either that the facility for long-term care provide full diagnostic and treatment services within its own program or that it operate in close relationship, administratively and geographically, with a general hospital.

If long-term institutions are operated independently and attempt to provide all the services that may be required for diagnosis and treatment, it is necessary to duplicate all of the equipment and personnel of a general hospital. This is expensive and unnecessary. Although such facilities must be constantly available for use by long-term patients they are not used with sufficient frequency and regularity to justify their being maintained exclusively for these patients. It is more efficient and more economical to operate the facilities for long-term care in close relationship with the hospital and to share its services. Ideally, homes for the chronically ill should be operated on the same grounds with general hospitals, under the same ownership and management, and as an integral part of the hospitals.

The most important argument in favor of combined operation is that better care is provided for the patients—and provided more promptly and with more efficient use of personnel, equipment and buildings. It is almost a certainty that the quality of care provided for chronically ill people can be brought up to good standards more rapidly by combining units for long-term care with gen-

nine states whose survey results are now available, pointing up similarities and differences in findings among them. Still to be incorporated in the 13 state study are data for Colorado, Connecticut, Georgia and Rhode Island.

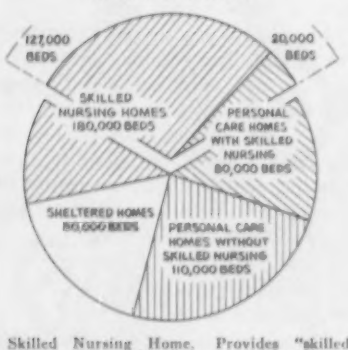
The survey was conducted principally by the state health department in most of the nine states reported here, often with the welfare department actively participating. In New York the Department of Social Welfare made the survey, and in Vermont the Commission on Chronically Ill and Aged provided the spark while the health department was responsible for execution of the study.

The general survey pattern involved a visit to the nursing home by a field agent, usually a nurse, who with the assistance of the administrator and other staff completed a schedule of information on each patient in the home on that day. Patient records maintained in the nursing home were used as needed and available. Data included the usual identifying information, date of admission, diagnoses (to the extent available), nature and extent of disability, nursing and personal care received, physician services, the amount charged, and the source of funds for payment. A basic limitation of the data is that they cannot go beyond what the nursing home administrator and his staff know and report about each patient. The principal inadequacy is incompleteness and lack of specificity of reported diagnoses.

In addition to the data about the patients, information was also obtained on the age of the institution and the number and types of staff employed. The physical characteristics of the homes were not covered in this study.

All participating states used identical survey forms supplied to them, and followed a manual which specified in detail the procedures for collecting data, processing of schedules, editing, coding, punch card layouts and speci-

FIG. 1: DISTRIBUTION OF BEDS BY TYPE OF FACILITY



Skilled Nursing Home. Provides "skilled nursing care" as its primary and predominant function.

Personal Care Home, With Skilled Nursing. Provides some "skilled nursing care," but only as an adjunct to its primarily domiciliary or "personal care" function.

Personal Care Home, Without Skilled Nursing. Provides "personal care," with no "skilled nursing care."

Sheltered Home. Provides "shelter" with its associated minimum services to aged residents who essentially manage their own care and affairs.

Table 1. COVERAGE OF THE SURVEY DATA

State	Total in State			Number Reporting [1]			Per Cent Reporting of Total [1]	
	Homes	Beds	Patients [2]	Homes	Beds	Patients	Homes	Patients
California [1,3]	487	9,288	7,548	126	3,047	1,816	25.9	24.1
Indiana	340	5,768	4,277	339	5,751	4,264	99.7	99.7
Maryland	102	2,385	2,029	96	2,203	1,874	94.1	92.4
Minnesota	199	3,335	3,202	187	3,087	2,964	94.0	92.6
New Mexico	32	333	254	32	333	254	100.0	100.0
New York (Upstate) [1]	752	13,653	11,609	96	1,651	1,391	12.8	12.0
Oklahoma	248	3,166	2,291	248	3,166	2,291	100.0	100.0
Vermont [4]	—	—	—	98	1,028	782	—	—
Wyoming	28	232	158	28	232	158	100.0	100.0

[1] In California and New York a planned sample was selected to participate in the survey. In the other seven states complete coverage was the objective.

[2] Partly estimated.

[3] Total includes 23 nonproprietary nursing homes with 932 beds; six of these homes, with 412 beds and a sample of 129 patients, are represented in the reporting group.

[4] Total in state not reported. Reporting group includes three nonproprietary nursing homes with 48 beds.

NOTE: A dash (—) is used in this and the following tables to represent "not known."

eral hospitals than it can in any other way. The morale, the pride in good standards, the staff and the technical competence already are available in hospitals for almost all of the services needed in a good unit for long-term care. Because all of the facilities needed for a high quality of medical attention are readily accessible, patients can receive better diagnostic and treatment services and receive them more promptly, easily and economically than they can in independent units.

From the point of view of both types of facilities, and of the community that supports them, combined operation of general hospitals and units for long-term care has the further advantage of making possible more flexible and efficient use of highly specialized, and consequently expensive, personnel and equipment. Another important advantage is found in the greater opportunities which this creates for research and for the training of professional personnel. The complaints heard so frequently that physicians, nurses and other personnel are not sufficiently interested in elderly and chronically ill patients and that they are not always prompt in finding ways to improve the patients' condition are a direct reflection of the regrettable separation which has existed between general hospitals and facilities for long-term care.

For all of these and other reasons, the operation of units for long-term care in connection with general hospitals seems to be the best form of organization of these services. It is not the only workable method of providing such care, however. Experience has fully demonstrated that good long-term care can be provided with reasonable efficiency in independently operated facilities provided they are so located, staffed, financed and administered that it is possible to transfer the patient to and from a good general hospital quickly and easily, keep him under the care of the same physician as he is transferred from one place to the other, and maintain for him a feeling of security and confidence in knowing that all necessary care will be given him when he needs it and that his home will be waiting for him when he is ready to return to it. When these conditions are met, it is possible to maintain for the nursing home patient approximately the same relationship between the nursing home and the hospital as exists for

Table 2. PATIENTS' CHARACTERISTICS

Selected Characteristics	Calif.	Ind.	Md.	Minn.	New Mex.	New York (Upstate)	Okla.	Vt.	Wyo.
AGE: Median age (years)	80	81	78	80	78	80	80	80	80
	Per Cent of All Patients								
65 years or over	88.2	91.5	83.3	89.2	80.3	90.9	90.0	85.3	83.0
85 years or over	28.5	28.6	22.4	28.1	19.3	26.0	24.9	28.6	26.6
SEX: Female	71.2	65.6	72.8	58.9	56.7	69.9	57.8	72.0	50.0
MARITAL STATUS: Married	12.1	8.4	12.9	10.1	13.0	10.4	8.6	11.6	11.4
Widowed	64.1	69.0	60.7	60.2	65.0	67.3	75.0	58.4	65.2
WALKING ABILITY:									
Unassisted, or with cane or crutch	31.4	45.7	48.8	54.6	51.6	50.0	49.1	45.1	58.2
Maneuvers with wheel chair or walker	9.6	7.2	4.1	8.1	8.3	8.8	7.7	5.8	10.1
Walks only with attendant's help	12.2	13.0	20.2	12.9	18.5	14.2	9.1	18.4	12.7
Never walks or wheels self about	44.3	33.9	24.9	23.6	21.7	26.9	34.1	27.6	17.1
DIAGNOSES (primary only):									
Cardiovascular, total	43.7	30.6	37.5	33.1	24.4	45.8	28.4	34.3	27.9
Heart disease	9.0	6.5	9.9	10.4	10.2	15.8	8.1	9.6	8.2
Hemiplegia (mainly from stroke)	24.0	17.4	14.0	13.2	0.8	13.6	15.2	0.1	3.2
Other circulatory diseases	10.7	6.7	13.6	9.5	13.4	16.4	5.1	24.6	16.5
Senility	15.9	27.2	18.4	18.2	20.5	13.6	12.6	18.2	35.4
Fractures (mainly hip)	11.1	8.9	7.9	9.0	9.5	8.3	7.9	6.6	6.3
Arthritis and rheumatism	6.2	6.8	6.0	7.8	5.9	6.1	7.9	5.5	7.0
Paralyses (excl. hemiplegia) and degenerative diseases of CNS	4.4	4.3	5.3	3.5	7.9	2.7	5.4	4.6	3.2
Mental disorders	1.9	7.9	4.5	1.8	2.0	1.9	9.4	3.2	3.8
Neoplasms	2.1	3.6	2.5	3.2	2.8	4.3	2.7	3.3	0.6
Diabetes	3.0	1.6	2.8	4.0	1.2	4.4	2.7	3.1	2.5
All other primary diagnoses	10.0	6.9	9.0	14.7	22.4	9.7	12.3	14.7	10.1
No diagnosis	1.2	2.3	3.3	3.2	1.2	2.0	8.9	5.5	3.2

fications for standard tabulations. This provided a rather high degree of comparability among data collected in different states. However, there are differences in use of certain terms in some areas which to a degree limited the uniform conduct of the survey and may account for some of the variations.

It became evident during the process of the survey that there were quite varying conceptions of the "nursing home" in the common usage of the term in different states. Some confine the term to establishments which offer a rather technical level of nursing care, while others in a looser use of the term embrace essentially custodial establishments along witht the medical-nursing type of home. An attempt was made to prescribe a specific definition of "nursing home" for the purposes of the study, in order separately to identify the establishments which might in the more technical sense be termed nursing homes. The practices in force in most of the participating states, however, were apparently not amenable to the rigorous distinction. The result, therefore, is that the establishments included in this report more nearly represent an admixture of homes devoted to skilled nursing care and homes furnishing predominantly personal care plus some skilled nursing.

According to the Inventory of Nursing Homes and Related Facilities conducted by the Public Health Service in 1954,[1] there are in the United States approximately 25,000 institutions with 450,000 beds in the broad grouping of facilities covered by that inventory. Of these, close to 8000 homes, with nearly 150,000 beds, are proprietary skilled nursing homes and personal care homes offering some skilled nurs-

[1]Solon, J., and Baney, A. M.: Inventory of Nursing Homes and Related Facilities. Public Health Reports, 69:1121 (December) 1954.

the patient who is receiving care in his own home and whose physician may hospitalize him and return him to his home with no break in the continuity of his medical attention and no serious damage to the patient's confidence and feeling of security.

HOMES FOR THE AGED

One of the factors that has tended to confuse thinking about homes for the aged has been a widespread lack of clear understanding that health is a matter of degree, not an absolute condition, and that chronic diseases characteristically begin insidiously and progress gradually through months or years of slowly increasing disability before the patient becomes bedridden. Often it is during this earlier phase of the illness, while the individual is still up and about, that he comes to the home for aged. He can look after most of his own personal needs, is able to dress himself, come to the dining room for meals, and carry on many of his usual activities. His heart disease, however, has reached the point where he is afraid he may have an attack and die alone if he continues to live in his own home with no one to be responsible for him. Or the elderly lady's arteriosclerosis has progressed to a phase in which her mental processes are slowing up, she is becoming forgetful, and she or her family is afraid that if she is left alone even for short periods she may leave the gas turned on or may wander away and be unable to get home.

With protected living arrangements, good supervision, and a comparatively small amount of care, these persons may get along well for considerable periods of time. They must be relieved of the responsibility of maintaining their own homes, however. Others must do the work involved in housekeeping, cooking and serving the meals, and maintaining the home for them. They also must have the protection of having a responsible person constantly available in case help should be needed and the added safeguard of good, regular medical supervision to protect the degree of health they still have, to control the progress of their disabilities so far as this is possible, to prevent or detect promptly any new illnesses or handicaps which may be developing, to treat their illnesses, and to give competent, kindly and understanding care as their infirmities increase.

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ing care (Fig. 1).[2] These are, by and large, the types of establishments represented by the patient data in the present study. The inventory, planned with close reference to the patient study which had been instituted earlier, used basically the same definitions for types of facilities as were used in the patient study. The inventory counts will provide a framework within which eventually to project national data from the findings of this study.

The data for New York and Wyoming which had been initially differentiated as to the more technical and less technical nursing care homes, have been consolidated here into a single group for comparative consistency with the other states. The separable data for these states, however, clearly demonstrate that when a differentiation is made between homes which primarily provide nursing care at a technical skill level and homes which furnish primarily personal care with little skilled nursing, a distinctly different picture of patients emerges for one and the other type. A more heavily disabled group is, quite naturally, found in the skilled nursing homes than appears in the largely personal care homes.

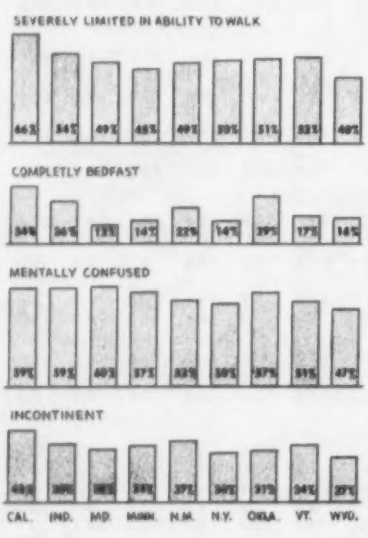
The nine states which are included in this preliminary report are listed in Table 1, with the number of facilities and patients represented by each. The information given in Tables 2 to 5 is based on the figures for "number reporting" shown in Table 1.

[2]Solon, J., and Baney, A. M.: Ownership and Size of Nursing Homes. Public Health Reports, May 1955.

PATIENTS' CHARACTERISTICS

Age. As Table 2 clearly shows, nursing homes care preponderantly for aged people. From 80 to more than 90 per cent of the patients in nursing homes in the states reported are over 65 years of age. Among these, many are quite aged; about one-fourth, generally, of all patients are over 85 years.

FIG. 2: PROPORTION OF DISABLED PATIENTS



The average (median) age of patients is, with remarkable consistency among the states, about 80 years.

Sex. Most nursing home patients are women, with their proportion varying among the surveying states from one-half to three-fourths of all patients.

Marital status. Most of the patients, as we would expect from their advanced age, are widowed. Additional numbers have never married or have lost their spouse through divorce or separation. Thus not many more than 10 per cent have a life partner to whom to turn under the stressful circumstances.

Physical and mental condition. Along with age, information about the degree of physical dependence of the patients is crucial for understanding the character of nursing homes. Figure 2 shows the proportion of patients in the various states who are incapacitated in various respects.

In most of the states, half or more of the patients are unable to ambulate at all or need some major mechanical aid or personal assistance to get about (see also Table 2). From one-fourth to one-half of the patients are in bed most of the time, and most of these are completely bedfast.

Half or more of the patients are mentally confused, at least part of the time. With near unanimity, the states report about one-third of the patients lacking bladder or bowel control. The lower proportion reported incontinent by Wyoming and the higher proportion by California (respectively, 27 per cent and 43 per cent) may in part reflect the relative availability of domiciliary facilities for the aged and infirm. We would expect that where such facilities are relatively more avail-

These are the elderly people who frequently are described as being "in good health for their age" and who can be kept so for long periods of time if proper attention is given to their health needs. For most of these persons there is no sharp line between the time they are "in good health for their age" and the time they begin to require nursing care. They may simply find it becoming a little more difficult each day to get up for breakfast. After a while they may regularly have their breakfast in bed but get up later and go to the dining room as usual for dinner and supper. Then they need longer rest periods in the afternoon and it becomes too much of an effort to get up for supper and they begin having tray service for two meals each day. Gradually, they spend increasing amounts of time in bed until finally it becomes apparent that they are "bed patients." Or the individual may have repeated brief "sick spells" in which he is bedridden for a few days but recovers sufficiently to be up and around until the next episode occurs. Gradually these periods come more frequently and eventually the time comes when he remains bedridden. Usually, however, it is impossible to predict at the beginning of one of these occasions whether or not this is the one which will leave him permanently in bed.

The speed with which an aged patient's infirmity progresses usually is related directly to the adequacy of the health protection he receives. With a good health program in the home for the aged, the progress of infirmity will be less rapid, the elderly people will remain on their feet for a longer time, they will tend to have shorter periods of complete helplessness preceding death, and they will live more satisfying and perhaps a little longer lives. To achieve this objective, however, the institution must recognize its responsibility for the health of its residents. It must face clearly the fact that the health of practically all of them has been damaged to some extent or they would not need the services of the institution, and it must recognize and meet its responsibilities as part of the community's resources for long-term care of chronically ill and disabled people. The fact that it may accept only persons who, at the time of admission, are still in the comparatively early stages, when the patient still is ambulant, does not lessen its responsibility for providing good health services. It

Table 3. PATIENTS' CARE

Selected Information on Care	Calif.	Ind.	Md.	Minn.	New Mex.	New York (Upstate)	Okla.	Vt.	Wyo.
	Per Cent of All Patients								
Level of Care Person Needs:									
Absolutely requires nursing home	73.0	57.0	—	63.2	61.4	16.2	52.0	54.3	27.2
Is hypothetically possible in own home if had one with family to help	17.8	34.8	—	31.2	24.8	69.4	30.8	36.3	57.0
Is essentially boarding care	8.3	8.2	—	5.3	13.8	13.9	14.8	9.2	15.2
Nursing Services Received:									
Full bed bath	64.9	58.3	57.3	43.4	40.9	52.0	44.4	62.8	36.1
Rub and massage	76.8	65.6	70.2	57.2	60.2	61.1	63.8	59.6	40.5
Medication	71.8	63.6	54.8	67.6	65.4	65.7	54.8	65.7	38.0
Bedpan	51.5	38.1	38.3	31.6	25.6	35.0	35.1	39.0	21.5
Enema	50.6	23.2	19.4	22.1	22.4	14.2	25.6	27.1	14.6
Hypodermic injection	23.3	13.7	10.9	13.3	12.6	17.9	15.0	13.6	4.4
Dressings	8.4	5.4	3.8	8.6	8.3	5.2	4.8	5.9	8.2
Take pulse, temp., or respiration	59.3	43.4	55.3	64.2	55.1	35.9	36.5	36.3	23.4
Personal Services Received:									
Special diet	29.2	14.6	19.6	19.6	25.2	21.6	15.4	28.4	21.5
Feeding help	32.7	21.9	29.6	23.0	22.8	19.4	23.0	24.2	15.8
Dressing help	48.3	52.6	53.4	51.7	48.8	41.4	59.5	44.9	41.8
Tub-bath or shower help	36.3	31.7	42.8	7.3	40.2	47.8	46.4	22.9	39.9
Care of hair	75.2	68.8	64.6	67.3	98.4	51.8	71.5	59.3	48.7
Shaving	21.0	25.4	19.3	27.6	25.2	17.2	31.2	16.6	18.4
None of Specified Services Received:	2.1	3.6	2.5	2.4	8.7	4.3	6.5	7.3	10.8
Physician's Attendance: Last Seen—									
In past 30 days	64.8	56.1	49.8	42.9	44.1	72.9	38.7	55.4	35.4
Over 6 months ago	9.6	14.0	24.9	17.1	21.7	9.2	25.2	14.1	34.2
Over 1 year ago	5.0	7.5	18.3	7.7	15.8	6.1	15.5	9.1	29.2
Length of Time Since Admission:									
2 years or more	26.8	26.7	27.5	30.4	14.2	38.7	21.9	32.8	23.4
5 years or more	7.8	5.4	5.3	6.5	0.8	9.9	4.8	8.5	6.3
	Number of Months								
Median stay to date	10	12	12	13	6	17	9	14	8

able, the population which would gravitate to the nursing homes would be a more disabled group.

Diagnoses. The diagnostic information gathered in the survey does not carry the same degree of validity as do the other, more objectively determined types of information. Wide variations exist in the availability of physicians' diagnoses, in record keeping, and in accuracy of reporting. Almost inescapable also is a suspicion, deriving from some differences which appear among the states, that the rules of classification and selection of primary diagnosis established for the survey were not uniformly followed. In their present preliminary form, and with recognition of the basic inadequacies of the diagnostic data, the results are given in Table 2 for the perspectives which they make possible.

Without question, cardiovascular diseases are more responsible than any others for these patients' need of nursing care. From one-quarter to nearly one-half of the patients in the various states were reported as needing care in a nursing home mainly because of a circulatory disease. Hemiplegia resulting from stroke figures largely in this group, as does heart disease.

Although not a definitive diagnostic entity, senility constitutes a major category within the reporting capability of the nursing homes. The range of figures for this condition from 13 per cent to 35 per cent, however, obviously reflects more the variations in availability of other specific medical diagnoses and in reporting practices than actual prevalence of this generalized condition as a primary cause for care.

Fracture as a primary diagnosis is reported for up to one-tenth of the patients. Fewer than this number are in nursing homes mainly because of arthritis; paralyses and degenerative diseases of the central nervous system (parkinsonism and multiple sclerosis, among others); mental disorders of a

has a twofold obligation: to protect the degree of health its residents still have, and to provide good care as their disabilities increase and full nursing service is required.

Many people still assume that homes for the aged serve only persons in good health and that they should not in any way be considered facilities for care of the sick and disabled. This attitude sometimes is zealously maintained even by persons responsible for the operation of institutions in which every resident has some degree of illness and infirmity. In many respects, this attitude reflects a commendable effort to place the emphasis in the institution's program upon the capacities which the residents still have rather than upon their disabilities, and to encourage them to function to the full extent of their abilities and to live as nearly normal lives as possible. These persons justifiably resent and oppose the encroachment upon their atmosphere of normal living of attitudes and procedures which may cause the residents to think of themselves as sick people. This is highly desirable. It should be encouraged and more widely adopted. It should not be permitted, however, to obscure the realities of the situation nor should it be carried to such an extreme that it denies the existence of damaged health among the people in the home and the need for good medical and nursing services.

Careful study of the people currently living in homes for the aged and of those in facilities described as nursing homes shows that there is remarkably little difference between them. At least 60 to 75 per cent of all people needing long-term care in facilities other than their own homes are in the older age groups. Consequently, most of the persons in nursing homes are elderly and many of the small, privately owned places officially classified as nursing homes prefer to describe themselves as homes for the aged. They can do so quite accurately. Similarly, most of the people in institutional facilities known as homes for the aged are in need of this type of care because they have some degree of chronic illness and disability. At the present time it is virtually impossible to draw any clear line of distinction between the places that are described as homes for aged and those known as nursing homes on the basis of the types of people residing in them.

psychotic, psychoneurotic or behavioral nature; cancer and diabetes. Many other conditions appear in small percentages.

PATIENTS' CARE

Level of care needed. An attempt was made in the survey to judge each patient's need for care in terms of the skill level or intensity level required in his care. On this judgmental basis, the question was keyed to whether the patient's needs could be expected to be met only in a nursing home or whether, with the supposed availability of a relative at home, he could conceivably have been managed in his own home.

Outside of New York's and Wyoming's data, the results (Table 3) show that in the opinion of the informants between one-half and three-fourths of the patients unequivocally require the nursing home setting. The particularly extreme degree of divergence of New York's data from this level is an interesting feature for which an explanation is not now at hand. Conversely—and with the same exceptions—from approximately a fifth to a third of the patients among the other seven states were judged to need the kind of attention which might be given in one's own home.

Whether by chance or by choice, nursing homes acquire some "patients" who are not actually in need of nursing care at all. From 5 to 15 per cent of the present residents were said to need mainly boarding care rather than nursing care.

Table 4. FINANCIAL ARRANGEMENTS FOR PATIENTS' CARE

Selected Financial Information	Calif.	Ind.	Md.	Minn.	New Mex.	New York (Upstate)	Okla.	Vt.	Wyo.
	Per Cent of All Patients								
Source of Funds for Care:									
Patient or family, in whole	61.6	40.2	71.4	24.0	39.8	44.0	25.1	56.9	26.6
Public welfare, in whole or part	31.7	58.7	24.8	71.4	57.9	55.7	70.8	36.7	69.0
In whole	11.5	44.5	22.2	61.5	45.3	50.3	70.8	17.8	51.3
In part	20.2	14.2	2.6	9.9	12.6	5.4	0	18.9	17.7
	Median Monthly Charge per Patient								
Charge for Care:									
All patients	$195	$114	—	$144	$ 91	$156	$ 89	$136	$ 98
Patients paid for by self or family, in whole	210	128	—	153	130	178	110	151	148
Patients paid for by public welfare, in whole	118	102	—	140	82	137	85	120	86

Services received. In most of the states, a majority of the patients receive bed baths, rub and massage, and medication. Taking of temperature, pulse and respiration is a common procedure. Bedpan service and enemas are given to large proportions of the patients. Hypodermic injections and dressings are far less common procedures, but also are far from negligible.

Personal services—assistance with bathing, toilet, dressing and feeding of patients—are obviously a heavy responsibility of the nursing home staff.

From 15 to 30 per cent of the patients are served special diets. The commonest of these are "salt-free or low salt" diet, "soft or puréed" diet, and "diabetic" diet.

Some residents receive none of these nursing or personal services. The proportion of these ranges from 2 to 11 per cent.

Physician's attendance. A point on which increasing interest is being generated is that of active participation of physcians in the management of nursing home patients. Actually, the data show that substantial proportions of the patients, in several states as many as one-third, have not been seen by a physician in more than six months.

Length of stay. The total length of time spent under nursing home care

The differences that presently exist between nursing homes and homes for the aged are found chiefly in the points of emphasis in their programs and in the services which they currently are offering. Even though the people in them are approximately the same and should have the same care, they are not generally receiving it. The differences in the facilities and services provided directly reflect the differences in concept of the character of the institutions that is held by the officials who are responsible for their operation.

Places known as homes for the aged, in general, are far superior to most of those described as nursing homes in their homelike atmosphere and in their emphasis upon their residents' continuing to live as nearly normal lives as possible. Many of them are seriously deficient, however, in their recognition of the residents' health requirements and in the provision of medical attention and nursing care. They regard themselves as homes for "well old people" and place their emphasis on this aspect of service. Nursing homes, on the other hand, tend to be superior to homes for the aged in their recognition of health needs and in the provision of medical attention and nursing care but considerably behind them in the recognition of the patients' social and emotional needs and in the provision of a homelike atmosphere with emphasis upon maintaining as nearly normal lives as possible for their residents.

As success is achieved in the efforts now being made to improve the health services in homes for the aged and the homelike atmosphere and attention to social and emotional factors in nursing homes, there will be less and less difference between the facilities operating under these names and the persons living in all of them will receive better care.

By whatever name they may be called, homes offering good care to elderly people who no longer can look after themselves in independent living arrangements are greatly needed in almost every community. It is important that they be homes in the best sense of the word and that they provide for each resident the best possible substitute for a good home of his own. This homelike atmosphere is needed as much—perhaps more—by the people whose

is not available in these data. Measured here is the length of stay in the particular home up to the date of the survey. Patients may, of course, have moved from one nursing home to another, may have had intermittent episodes of nursing home care, and will be staying on in the home beyond the time tallied in the survey.

The average patient has been in the present home for from a half year to as much as a year and a half, varying with the state. In several states, nearly one-tenth of the patients have been in the home for five years or more.

FINANCIAL ARRANGEMENTS

Source of funds. The cost of nursing home care, extended over a lengthy period of time, poses a severe financial problem for many—probably for most—families. The extent of the rôle undertaken by public welfare funds in financing such care is therefore not entirely surprising (see Table 4). In six of the nine states, more patients are paid for through public welfare funds than are financed through their own or family funds. The proportion of welfare patients goes up as high as 70 per cent of all nursing home residents (Oklahoma). This high portion is reached in Minnesota and Wyoming when part-payment by public welfare as well as full-payment is counted.

Charge for care. The median monthly charge for nursing home care varies from about $90 in New Mexico and Oklahoma, to $195 in California. Public welfare consistently pays less than do private pay patients; the welfare median runs from about 60 to 90 per cent of the private-pay median. No data are available as to differences in accommodations, between or within homes, occupied by these two groups.

Table 5. STAFFING AND AGE OF THE HOMES

Staffing and Age of Homes	Calif.	Ind.	Md.	Minn.	New Mex.	New York (Upstate)	Okla.	Vt.	Wyo.
	Per Cent of Total Staff								
Staff Distribution by Type:									
Licensed graduate nurses	11.6	3.4	7.5	7.5	2.7	9.4	1.1	12.1	0.9
Licensed practical nurses	18.9	8.5	10.7	6.9	6.9	24.0	8.9	16.2	0
Other nursing staff	41.3	55.5	41.1	46.2	46.8	40.7	55.2	33.2	52.6
All others	28.2	32.5	40.8	39.4	43.6	25.9	34.7	38.6	46.5
	Number of Patients per Staff Member								
Patient/Staff Ratio:									
Total staff, all types	1.8	2.4	2.2	2.5	2.7	2.1	2.5	1.9	2.8
Nursing staff only	2.5	3.5	3.6	4.1	4.8	2.8	3.8	3.2	5.2
	Per Cent of All Establishments								
Age of Establishment:									
Less than 1 year	18.5	13.6	—	15.5	31.3	7.8	34.2	14.2	32.2
1-5 years	54.9	47.2	—	43.9	53.1	40.8	41.5	27.6	39.3
5-10 years	17.2	25.7	—	29.4	6.3	26.6	16.9	28.6	3.6
10 years or more	9.4	13.6	—	11.2	9.4	24.7	6.9	27.6	14.3

STAFF

The relative numbers of different types of staff employed in nursing homes is shown in Table 5. The extent to which registered graduate (professional) nurses are used varies widely. They constitute only 1 per cent of all staff in Oklahoma and Wyoming, but up to as much as 12 per cent in California and Vermont. New York stands out in the use of licensed practical nurses, who represent one-fourth of all nursing home staffs in that state. By far the most numerous type of personnel in all of the states are unlicensed practical nurses, nurse's aides, attendants and similar nursing help.

Aside from skill level, an important consideration is the number of

disabilities have progressed to a point where they are bedridden or chair-bound as by those who still are able to be up and about.

The importance of offering the resident the security of continuous care as he becomes increasingly infirm has already been pointed out. It may be mentioned again because of its great influence on the individual's well-being and because of its significance in planning new facilities for care of elderly people. No one can feel that a place is truly his home if he knows that he can remain there only so long as he requires little or no help. The question that gives rise to such tragic insecurity and fright among older people alone in the world is "What will happen when I can't take care of myself any longer—when I am old and sick and have no one to look after me?" Entering a home for the aged that will keep him only as long as he needs little or no care does very little to relieve these fears. No home for elderly people, therefore,* should be established or operated exclusively for persons who are ambulant and comparatively self-sufficient. The institution might well maintain one unit for persons who are up and about, while caring for others in another section of the building, but it should not accept responsibility for care of a resident only for the limited period during which he remains comparatively self-sufficient. It should be recognized that the individual's disabilities must be expected to increase and the institution should offer its residents the security of a permanent home and the knowledge that here are people concerned for their welfare and prepared to care for them as long as they need help.

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staff in proportion to patients. A rather common ratio seems to be about two patients for every staff member, although several states approach a ratio of as many as three patients per staff member. Considering nursing staff alone, there is on the average one nurse for every two and one-half to five patients.

AGE OF ESTABLISHMENT

The growth of nursing homes has been very dynamic in recent years. There is currently a great deal of mobility in the opening and closing of homes. As Table 5 shows, many homes have opened within the past year. In three states—New Mexico, Oklahoma and Wyoming—as many as one-third of the homes have been in existence for less than a year. On the other hand, in New York and Vermont, where nursing homes probably have had a longer and more stabilized history, fully one-fourth of the homes have been operating for more than 10 years.

CONCLUSION

From this review of newly collected information about nursing homes flows a fundamental concept of the place they occupy in the care of the chronically ill. They accommodate, we have seen, predominantly aged people who are quite severely disabled and suffer a heavy burden of chronic disease. These people spend long periods of time in the nursing home, and in many instances have made it their permanent abode. These facts emphasize the essentially dual capacity in which the nursing home must serve—to provide a residence and to provide an active nursing service. Acting in the rôle of a "home" for their long-term or permanent residents, these establishments must serve social, emotional and spiritual, as well as physical, needs. For the type of patients who are characteristic of these homes, they must also serve as medical care institutions. They offer, in effect, a type of care which is intermediary between the hospital and the family home. Their nursing services are designed and administered for medical purposes, and their personal services, for physically and emotionally sheltering and supportive purposes. Lack of development of one or the other of these aspects makes something less than a professional and desirable nursing home.

There are among so-called nursing homes today legitimate differences of intent. Some, although commonly known as nursing homes, do not really presume to furnish the level of skilled nursing care which is appropriate to a medically oriented facility. Theirs too is an appropriate rôle, for the type of personal care offered, provided they are at the same time prepared to arrange for transfer to another type of facility if the patient's needs should require it. As was noted in introducing this report, the picture presented here suffers from an intermixture of data for homes operating at somewhat different levels of care. In some states there has been progress in making at least some gross differentiations among homes and in setting standards which are appropriate to a designated level of care. The experience of this study suggests, in confirmation of what some of the states have already done, a basic two-level categorization hinging on a distinction between "skilled nursing care" and "personal care."[2] Discussion about these types of facilities and about appropriate standards of care may then be more clean-cut and avoid much of the confusion and disagreements so easily aroused at present. Raising of standards to medically oriented levels will then be more easily and more smoothly accomplished for those nursing homes which aspire to provide skilled nursing care within a medical care context.

With respect to the medical function, without which the home is a domiciliary facility rather than a nursing home, there is a certain quality of responsibility which is essential. Its residents are sick people (albeit chronically rather than acutely) who are in need of appropriate nursing care. Such patients should be under the active continuing care of a physician, and the care administered to them by the nursing home personnel should be under the active direction of a physician. Less than this negates the home's claim to being a medical care facility.

As a medical care facility, the nursing home also has a responsibility for helping to assure prompt and unhampered transfers to a hospital when indicated. For the proper management of the nursing home patient, he should be assured of ready access to the diagnostic procedures and the more technical and intensive medical treatment which the hospital is equipped to provide. He also stands to gain if the nursing home on a continuing basis calls on the hospital's staff and know-how for educational and consultative purposes. A close working affiliation between hospital and nursing home, with interchange of records, orders and staff experience, offers a professional arrangement desirable for both institutions and facilitates continuity in the care of the patient.

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*See classification presented in the introductory report of the Inventory of Nursing Homes and Related Facilities (cited in footnote 1).

Beautiful surroundings and modern furnishings have supplanted the drab walls, threadbare carpets, and cast-off furniture, once considered "good enough for the old folks." Now—



The main lounge of the Mather Home in Evanston, Ill., (also shown in color on the cover of this issue) illustrates better than words the "new look" in nursing homes.

Color Puts the "Home" in Nursing Home

RAYMOND P. SLOAN

WE CAN always send it to the Old Folks Home."

"It," in this particular instance, was that decrepit, overstuffed armchair long since relegated to the attic, and now the subject of family debate. "It's just a dust collector. Whatever will we do with it?"

So it happened that the old tapestry covered chair, with other equally forlorn companion pieces, ended their days in an institution, to provide what was optimistically described as a "homey atmosphere." For institutions in those days, we may recall, were institutions and their inmates were inmates. To quote precisely from Mr. Webster—"Those confined or kept in an institution such as an asylum, prison or poorhouse."

The term "geriatrics," then heard infrequently, provoked raised eyebrows and a rush for the nearest encyclopedia. We had old people, to be sure, but viewed by professionals and laymen alike, old people were old people and there was little that could be done about them.

What a contrast, therefore, to read in public print today such statements as—"Morale is the chief hurdle to be met in handling the problems of our aging population, according to doctors, psychiatrists, psychologists, nurses, social case workers, and other counselors in the field of geriatrics. Frequently, it is not the state of health of the individual that is the major consideration, but the state of mind that influences the health factor."

That state of mind, it has been proved, is influenced directly by our surroundings. Color, we have come to know, plays an important rôle in the emotional and mental health of the individual, exercising a definite influence on the brain and nervous system. Once this fact was established, changes became apparent in those institutions devoted to the care of long-term residents.

Characteristic of the new point of view is less emphasis upon the word "inmate" with its implications of deterioration and last resort, and, as substitutes, more generous appellations such as "residents" or "guests." Similarly, the word "institution" or "home" has become demoded in favor of the friendlier term "club" or "residence."

Rehabilitation, so essential to human bodies and minds suffering from depletion and failure owing to one cause or another, is equally applicable to the physical properties surrounding any such program. New concepts, new



Colorful draperies, acoustical ceiling, and tables for four improve appetites in the dining room of the Mather Home.

hopes need to be nourished by light, by cheer, by the stimulus born of congenial surroundings.

Speaking specifically, that old tapestry armchair in its present drab state could never by the greatest stretch of imagination become a morale builder. Given some sort of rehabilitation program in the form of new dress or slip cover, it assumes potentials, unless, by chance, debarred by its very depth and proportions from being compatible with stiff joints and trembly limbs.

Unfortunate, indeed, that a large percentage of services rendered our long-term patients and residents (frequently a combination of the two) must take place in buildings never originally designed for such purposes. However, some recognition of the need for rejuvenation, accompanied by professional guidance where possible, will go far toward overcoming basic handicaps. It is surprising what can be accomplished by the application of paint in becoming colors, wall coverings serving as a face-lifting process for sad and sallow surfaces, by fabrics tough enough to take almost anything, yet sufficiently colorful to make life worth living. Such devices can be miracle workers, indeed, in providing a stimulating atmosphere not merely for residents, but for personnel and public alike. These tools must be employed effectively, however, with some knowledge of the habits, the tastes, the preferences of those for whom they are designed.

There is a vast difference in planning backgrounds for guests who are transients and for those whose stay stretches into weeks, into months, into years, even. How often we find ourselves in settings that we admire, but for which we hold certain mental reservations — "Extremely attractive, but I'd hate to live with it all the time." Which is another way of saying, "We can put up with almost anything temporarily." Unfortunately, the residents of buildings devoted to geriatrics and long-term illness must learn to adjust themselves to their surroundings; the more need, then, for providing backgrounds that are stimulating yet that will wear well.





Above; the lounge and, below, the library of the Mather Home in Evanston. The open fireplace in the lounge, and pine paneling and bookshelves in both the lounge and the library make the residents' lives pleasant.

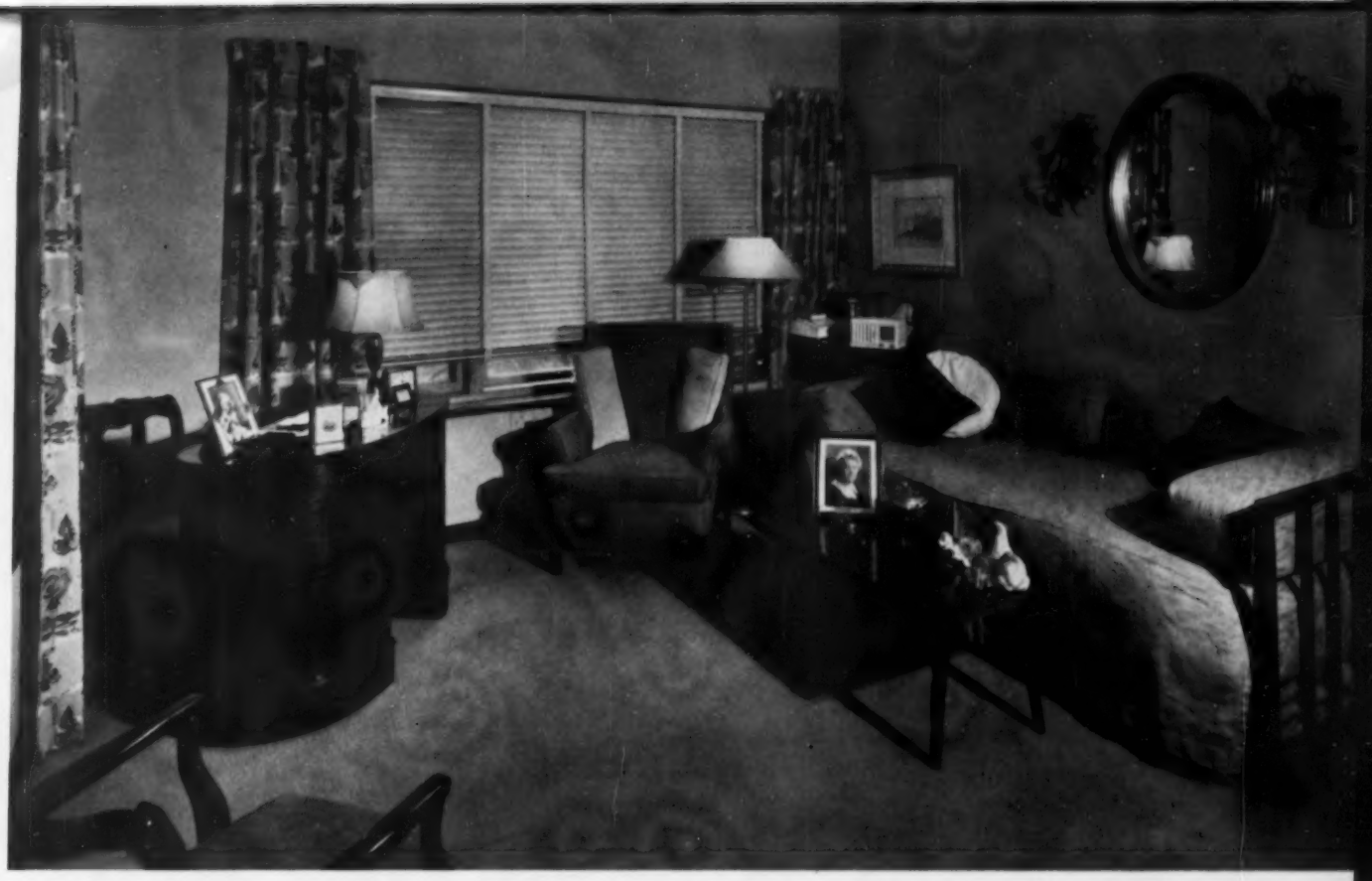
First, what about color? For surely no one needs to be convinced that we are living in an age of color. Cast an eye about the average American home. Watch Mr. Citizen as he rolls down the street in his new automobile, observe him selecting a new necktie, ask him what kind of pictures he takes, what kind of movies he prefers, what he thinks about colored television. Borrow his latest ball point pen. If it doesn't reflect his color preferences, it isn't the fault of the manufacturer.

Should there be any doubt about the reaction of color upon those who are incapacitated through old age and its accompanying disabilities, try tying a bow of bright blue or pink ribbon on that old lady who is bedridden. Watch the new zest for meals born of surroundings that are cheerful—yellow walls with windows framed in flowered chintz, all rose, blue and green. Note carefully the pride with which the occupant of a newly rehabilitated room points to her recently acquired blue bed cover.

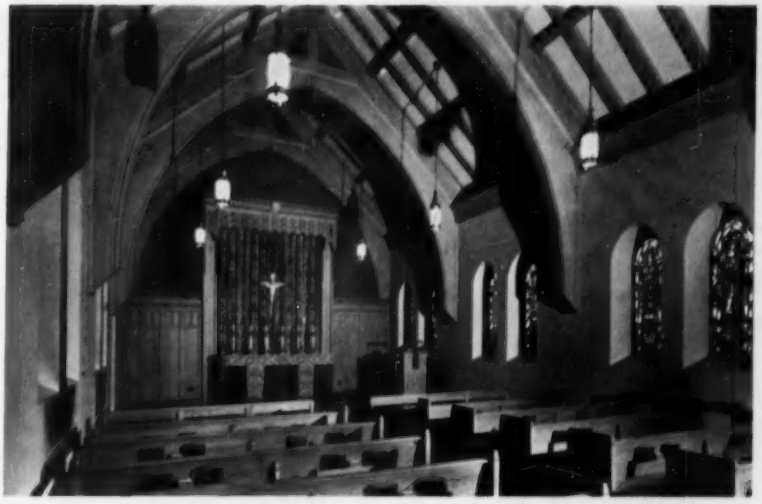
Much has been written and said on the subject of color preferences. The significance of such studies and the authenticity of their conclusions are difficult to evaluate. We have been told on numerous occasions that children favor strong colors, that women generally prefer the warm tones—red ranking high on their list of favorites; that men choose the cooler portions of the spectrum, blues being their first choice.

Practical experience and contact with people in the older age brackets would point incontestibly to certain preferences. Heavy, dark shades and tones, sometimes characteristic of the so-called modern style of decoration, are not as popular as are the lighter, pastel tints. A compromise is always possible, however, such as that achieved in one residence in which a hallway painted in gray is enlivened with benches, half-way resting spots, upholstered in brilliant red. The contrast is dramatic.

Old people, particularly women, like pink and rose, a preference shared by the public generally at this time. This does not mean that their living quarters should be flagrantly these colors. The backgrounds of residents' rooms, in fact, might better be kept in neutral tones—beige, perhaps, not



Above: The bedrooms in the Mather Home are arranged to be used as "living rooms" also. Below: The chapel for residents of Mather Home.



dull, cloudy, dreary tones of beige, but those that are fresh and clear, possessing, even, a warm pink cast. Against such a background, stronger contrasting colors may be introduced at the windows, in the upholstery, on the bed covers.

Space restrictions are an important factor in developing a design for living in residences for the aged, for long-term patients, and for convalescents. Their rooms, necessarily small, remain mere remnants of what once was home, reflecting within the area of a few feet lives that are but memories.

Light, clear colors will help create an impression of greater space and size. Woodwork, too, painted the same color as the walls or just a shade lighter or darker is an aid in making rooms appear bigger than they actually are. For the same reason care should be taken to avoid selecting curtains and upholstery fabrics in large scale design. Furniture, likewise, should be of proportionate dimensions, light enough for residents to move about on occasion, yet sturdily built and easy to get in and out of. Roomy, cushiony lounge or club chairs are not always what they appear to be, for older people anyway.

Design for living in these residences might well include suitable facilities for the display of souvenirs, pictures and knick-knacks. What if a hanging shelf does encourage collectors' items? Or a wall surface invite a gallery of family photographs? Or a plant stand or window box display odd assortments of seedy specimens that refuse to respond to even the greenest of thumbs? They're conversation pieces —interesting subjects of chit-chat over a cup of afternoon coffee.

The test is, do rooms assigned to these particular guests meet their actual tastes and needs, or do they represent what in the opinion of those responsible for their designing is suitable? Some attention to the likes and to the dislikes of those who spend the balance of their years living and waiting—too frequently lying and waiting—would be rewarding even though it did not result in pretty pictures for the world outside to admire.

Public areas provide opportunities

for bolder and stronger color effects, affording a welcome change of pace from the more subdued bedrooms. Foyers, halls, lounges, dining rooms, rooms for occupational therapy and for special treatment all are logical subjects for color treatment. Yellows and greens, particularly the blue-greens and the green-blues popularly designated as aqua or turquoise, are interesting, to which may be added for dramatic accent the more brilliant corals and reds, or the rich marine blues.

A recently rejuvenated lounge illustrates these principles. The walls are a soft shade of blue-green; the ceiling a tint of the same color. An interested friend donated a wall-to-wall carpet in a neutral beige. Incidentally, carpets today, like many other things, aren't what they used to be: they're definitely better, fabricated and woven to withstand the hardest wear, as witness their increasing presence in the foyers, public rooms, and doctors' offices of our general hospitals.

To continue—windows of this room are treated with an inexpensive, but effective, flowered chintz in which green, red, yellow and white form a pleasing design. Upholstery colors pick up the yellow and greens, with a dash of red to add an extra fillip to a couch.

Another less spacious lounge has been given added dimensions through perspectives provided in a scenic paper applied to one wall area—a rural scene with rolling landscapes, dotted here and there by farmhouses, with figures of men tilling the soil, women chatting at doorways as they watch the children playing in the front yard. And as comic relief, the farm dog barks at a group of cows.

It tells a story, a story of home, of nature. The viewer can almost smell the earthy brown, freshly turned soil, whose varied tones, coupled with the leaf greens, the barn reds, the summer cloud white, all fresh, clean and invigorating, offer a wide variety of colors for both background and accent.

BRIGHTEN THOSE CORRIDORS

Corridors discovered in another residence, which for years were merely dark passages and nothing more, in their shabby dress of dull tan, have won enthusiastic acclaim from those who tread them daily—many times daily. This feat was accomplished simply by a refresher treatment of two shades of green—clear, light upper areas in contrast to a darker dado.

Yellow, and this is a point on which almost every authority will agree, is the color of cheer. Because good humor induced by cheerful surroundings is essential to good appetite, yellow becomes logically a favorite for dining rooms, particularly where such facilities, as so frequently happens, are located in sunless portions of the building.

Yellow, too, is an aid to lighting, having a reflective value of approximately 70 per cent, and lighting is important where older people gather for meals. It is important everywhere, as a matter of fact, although some old eyes that remain healthy have grown weary from years of use and are sensitive to too strong light. It is not unusual amidst favorable "club" environments to witness groups engaged in conversation following the evening meal chatting happily together in semidarkness.

Color as therapy has demonstrated its efficacy in those rooms and floors allocated to the bedridden patient. Here, the cooler, more restful tones—the blues, the greens, in their various combinations, the gentle yellows—are preferable. One residence has been particularly successful in restricting the colors of its bed patient areas to these calming colors, and for contrast has employed warm tones in adjoining lounges to which patients are wheeled, also to a dining room on the same floor. Such treatment affords variety and contrast from restful areas to more stimulating backgrounds which induce a sense of well-being.

Fortunately today we have at our disposal a wide variety of "tools" with which to work in accomplishing pleasing and therapeutic results: wide varieties of color tones ready mixed by the paint manufacturers, wall coverings and scenic papers with which all manner of tricks can be played to make things appear not at all what they are, fabrics of the most unsuspected origins, many of which at surprisingly low cost combine durability, practicability, good looks, and comfort. For those who would favor the modern look, there are the leathers, both real and make-believe, and numerous members of the even more recent plastic family. There is really no end to it.

And lest anyone insist that the older generation clings to the traditional—the patent rockers, the Morris chairs, the prickly mohairs of their youth—and are resistant to modern feeling, our final glimpse into a rejuvenated residence may be revealing and convincing. There they are sitting securely on cherry red stools before a bright yellow cafeteria counter in a modern coffee shop, in company with their companions and guests, swapping reminiscences over their tea, coffee or soft drinks. This is the modern concept of a proper atmosphere for building and maintaining morale, based on the premise that it is not the state of health of the individual that is the major consideration in meeting this problem of geriatrics, but the state of mind that influences the health factor.

The Best Homes Work With Hospitals

IRVING BASS

Executive Director, Sephardic Home for the Aged, Brooklyn, N.Y.

MEDICAL and welfare services, and the relationship between them, are shaped by the needs of the people they serve and the directions in which these needs develop. The modern hospital and the modern home for the aged were organized to meet human needs and both are continually changing in response to the changes in the needs they serve.

At one time these two institutions were not concerned with each other and had little in the way of relationship. However, as times changed the needs which they met brought them together and the hospitals and homes began to develop connections. The present time is one of great change in this respect.

The first homes for the aged existed as parts of the county homes established for the indigent of all ages. In time there began to appear homes ex-

(*Continued on Page* 148)

Design for Care of the Chronically Ill

The physical plant, setting and surroundings must provide for the special needs of long-term patients

MANY of the same considerations involved in the planning of general hospitals confront the planners of nursing homes. The individual needs of their particular patient group make nursing home design quite unique. Outside these specialized areas of planning, the criteria established for general hospitals should be followed generally.

Unlike most patients in general hospitals, the patients in nursing homes are long-term residents. They have not left their homes for a limited period of treatment but to all intents and purposes have moved to a new home. The new home—the nursing home—must not only supply the necessary medical and nursing care to effect cures and maintain health, but must be able to meet the patients' needs for affection, emotional security, social contacts, recreation, spiritual devotion, education, rehabilitation and congenial work or creative activities.

The physical plant, setting and surroundings, then, must be designed to provide for these needs. Nursing homes above all should approximate the home feeling and atmosphere as closely as possible. A sombre, institutional character must be avoided.

One means of approach to a homelike quality is to keep the nursing home as small as is consistent with the economical maintenance of essential services and quality of care. Homes with capacities of 25 to 50 beds are considered to be of the most practical size. This range has advantages from the administrative standpoint in that small units are easier to operate to give individualized service.

Whatever size is selected initially, consideration should be given to the possible need for future expansion. Such expansion should be capable of being accomplished expediently, economically and with as little interference with the operation of the nursing home as possible.

It is recommended that nursing homes be of only one story unless they are to be so large, or the site is so small, as to make this impractical. Many advantages are to be gained in the one-story scheme. It eliminates the need for stairways and elevators and can ease the movement of patients, staff, equipment and supplies from one part of the building to another. It makes direct access from indoors to outdoors easier and considerably reduces the danger from fires. An informal, domestic character is much more readily achieved in a one-story building, and finally, one-story buildings generally lend themselves more readily to future expansion than multistory buildings do.

It should be possible to minimize institutional character in nursing homes through open informal planning taking advantage of natural light, air, outlook and outdoor activities, and through the provision of generous areas for patients' living and recreation. Color, decoration, harmonious furnishings and landscaping, thoughtfully used, can be most valuable in achieving informality. Soundproofing, acoustical treatment, light and temperature control, agreeable lighting, comfortable furniture, and other amenities relating to the patients' physical comfort should be installed.

EXTERIOR DESIGN

The exterior of the building should fit into the topography, and landscaping of the site should be pleasant to look at and domestic in character. Landscaping usually enhances design and setting and, in addition to planting, should include terraces with comfortable furniture, recreational grounds and garden areas.

The main entrance should be inviting to approach and should lead to a public lobby designed and decorated to give a pleasing first impression and gain the confidence of patients, their families and visitors. The use of steps or ramps leading to entrances should be avoided.

INTERIOR ARRANGEMENT

The use of wide corridors, introduction of natural light to corridors where possible, keeping corridor lengths as short as possible, and eliminating dark, congested areas are desirable. It is not felt necessary, as is the case in general hospitals, to keep visitors' and patients' areas and traffic so isolated, to have so many areas of the buildings from which patients are excluded. Neither is it felt mandatory to have just one, or perhaps two, carefully policed exits or entrances for patient use. Since the idea is to make the patient feel at home, he should feel free to meet his visitors where he likes, to mix at will with other patients and the visiting public, or at least to observe without restriction their coming and going. He should be allowed the freedom of the building or grounds as long as it does not interfere with the actual well-being of other patients, or seriously detract from the efficiency of operation of the nursing home.

CONTROL

The usual hospital requirements for supervision of the patients' bedroom area from the nurses' station should be adhered to. In addition, visual control by the professional staff of recreational

(*Continued on Page* 82)

Based on preliminary studies conducted by the Division of Hospital Facilities, Public Health Service, U.S. Department of Health, Education and Welfare.

THERE ARE SOME BOOBY TRAPS IN THOSE BLUEPRINTS—

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PLANNING a hospital for the chronically ill begins with an entirely different set of considerations from those used in planning the acute general hospital. The length of stay is measured not in days and weeks but in months and years. A large percentage of the chronically ill require only custodial care. For these reasons the center of gravity in primary planning considerations shifts from the nursing personnel to the patient. This does not imply that the problems of the nursing staff are to be ignored any more than considerations of the comfort and well-being of the patients are ignored in planning for the acutely ill.

Following are some specific instances in which physical facilities provided for the care of long-term patients often fail to meet either their special problems or the peculiar nursing requirements of their care.

GROUNDS

The hospital or home for the chronically ill or the custodial institution is the patient's home. As such it should be set in as informal an atmosphere as possible. Too many of our general hospitals are set in backgrounds of formal lawns. More than the general hospital the chronic institution needs informality. Shady areas for informal bench groups or assemblies of wheel chairs, or little garden houses should be set aside for patients. No wall, physical or psychological, should be erected between the grounds and the areas outside. The shut-in yearns for a look at the world outside. There should be no walls, hedgerows or the like. Instead, convenient shady spots should be provided where the wheel-chair patient may roll his chair right to the edge of the public walk and say "howdy" to the passerby. It hurts no one and may do a lot of good.

Promenade Roofs and Solariums. It is a fact that where solariums and sun decks or roofs have been provided in general hospitals they have been little used and decreasingly so in the recent nurse-poor years. Probably this has been the chief contributor to the trend toward elimination of such facilities from recent planning. In the case of long-term patients the relatively close supervision required by the acutely ill does not generally obtain, and sun roofs and solariums should be provided if it is at all possible.

PATIENTS' ACCOMMODATIONS

It would seem elementary that patients who are *ambulant* or *chairfast* should not be required to climb out of high hospital beds. For acutely ill patients, the position of their beds in the room, the relation of their beds to others, the windows and lights are of minor concern. Any hospital worker will testify that the contrary is the case with long-term patients. The slightest detail of their surroundings may become a source of aggravation, complaints and quarrels.

The Rigs layout of from two to six beds to a room or cubicle, arranged parallel to the main axis of the room, has many advantages in the planning of general hospital facilities but for patients who are able to spend large portions of the day out of bed the Rigs ward is not advisable. The reasons for this are precisely those which recommend it in the first instance. In the Rigs ward there is a definite economy of space and a greater sense of privacy than in the perimeter ward. These factors render this ward arrangement unsuitable for wheel-chair or crutch patients who require large floor areas. Another factor against the Rigs ward for chronically ill patients is the greater difficulty in servicing and supervision.

The arrangement of a large ward most nearly combining the features of individual rooms yet remaining a large ward—with its definite advantages from the control and administrative angles—is that in which the ward is divided into individual cubicles by partitions at right angles to the walls. Each cubicle is provided with a window—at once removing a common object of contention among long-term patients. Each cubicle may also be provided with a built-in clothes closet for the ambulant and chairfast who in most institutions are urged or required to dress in street clothes rather than hospital apparel.

An additional piece of equipment which should be provided in such a cubicle is a small combination cabinet-writing table. A width of 7 feet between cubicle partitions provides adequate space for a side chair and a wheel chair. By this arrangement the patient has the utmost privacy consistent with the maintenance of the large dormitory ward.

Institutions that care for a high percentage of ambulant and chairfast patients which for one reason or another are unable to provide personalized facilities for their patients should at least provide properly supervised locker or clothes rooms for patients' daytime apparel.

LIGHTING

Reading is the chief form of activity for the average long-stay patient. Thus room lighting should be of sufficient intensity for reading. Since it is not advisable to have too high a level of general illumination in the hospital room it is best that the reading light be at the patient's bedside. There is now available, even to the low initial cost institution, a fairly wide range of lighting systems and fixtures. Several types combine direct reading light with indirect general illumination. There are arrangements of reading and night lights as well as reading and examination lights.

Whatever the lighting scheme, it is extremely important that the reading light at the patient's bedside be controllable not only by the patient but also from a central point at or near the nurses' station.

TOILETS

Even institutions that provide all types of costly arrangements for wheel-chair patients have in the main neglected to provide for the patients' negotiation of the space from the wheel chair to the toilet seat. In the first place, no currently standard arrangement of toilet stalls is large enough to admit the wheel chair, with the result that the trip to the toilet for many patients involves the assistance of the attendant. The act of assisting a person from a wheel chair to the toilet seat and back again is often a back breaking job and in a narrow toilet compartment it requires the agility of a Houdini.

The problem is easily resolved by providing at least one stall in each toilet room of sufficient width to admit a wheel chair. The extra space should be provided at one side of the water closet. The stall should be equipped with a horizontal grab rail all around and almost any patient who can get out of bed can negotiate the project without assistance. If help is needed there is at least room in which to give it.

Another detail in the water closet which is a constant problem with the chronically ill is the flushing arrangement. Some patients who can make the toilet seat cannot operate the flushometer, involving as it does at least an additional 180 degree turn and not inconsiderable manipulation for the handicapped. The floor treadle is unsatisfactory because of the difficulty of cleaning around it. A device which has not been sufficiently tested in hospitals is one similar to the railroad toilet in which the flushing handle is at the side of the water closet.

LAVATORIES

Projecting shelves must never be installed at lavatories. It should always be assumed that any person with a chronic illness is just barely capable of standing. (While this is true of only a relatively small percentage of such patients the assumption is a bow in the direction of safety.) It takes very little to upset his balance. In the event of loss of balance he will reach for support for the nearest projection. After a number of accidents in one institution a considerable number of shelves that had

ARCHITECT LISTS PITFALLS IN PLANNING CHRONIC FACILITIES

been provided under mirrors in patients' washrooms had to be removed. Receptacles for toilet articles, shaving equipment, and the like should either be recessed in the wall or be provided integrally with the lavatory.

Remember the large proportion of your patients who are chairfast. Not less than one-third of the patients in any institution for the chronically ill are confined to wheel chairs yet how infrequently facilities are provided to make just living easy for them! In washrooms, mirrors at lavatories should either be set at a height convenient for the use of the chairfast or at least a reasonable number of such mirrors ought to be provided. Mirrors set with their tops about 4 feet from the floor and inclined slightly outward are best.

BATHROOMS

The majority of male and younger female patients prefer showers. If a shower stall 4 feet wide and a rust-resistant wheel chair are available, chairfast patients will take their own showers. For the ambulant, a seat within range of the shower head, a nonslip floor, and a grab rail around the shower stall should be provided.

The water controls must be outside the shower stall. No sick person should be required to adjust the heat of his own shower water — the danger is obvious — and it should not be necessary for the attendant to get wet in helping the patient.

There are always some patients who will require the tub bath. Even here it is possible for many patients to be self-sufficient, or nearly so. The tub should be so set that it is free standing at least on three sides. A slab or shelf can be set at the free end of the tub so that the patient may sit on the shelf then let himself into the tub by a sort of gradual slide. The tub height can easily be fixed at the level of the wheel chair so that it is easy for the patient to slide from chair to the bath shelf. This method has been in use for some years in an institution for the infirm, with excellent results. With assistance from a nurse or attendant a bedfast patient can be bathed in a tub so arranged without back strain. Recently an arrangement has been suggested in which the tub is elevated and is entered by means of steps on one side. This arrangement, in addition to adding an element of increased cost, actually adds hazards.

DINING FACILITIES

There is no reason, other than that it has always been done that way before, that patients who are out of their beds a large part of the day should be required to take their meals in or at their beds. Where the practice of feeding the ambulant or chairfast patients in dining rooms, alcoves or merely in a part of the ward free of beds has been tried it has had a salutary effect on the patients. It makes for easier feeding and certainly promotes cleanliness.

The easiest way to feed a group of patients is at a table. If a proper type of table is provided even the wheel-chair patients can be easily fed that way. The large round table with a central pedestal leg permits wheel chairs to be moved close to the table edge.

In institutions where there is not a liberal amount of space, the dining room can do double duty as day and dining room and even triple duty as dining, day and activity room. It certainly is advantageous and desirable to get patients away from the bedside for as long periods as possible.

UTILITY ROOM

Some hospitals for the chronically ill have provided completely equipped utility rooms; others have gone to the other extreme and provided no means of implementing nursing technics. Of course, the range of chronic diseases runs from the types involving nursing service fully equal in extent to that in acute general hospitals to the out-and-out custodial cases requiring attendant care only. The extent of nursing facilities requires careful consideration for every institution on the basis of the special requirements of that institution.

In making up an equipment list the special problems unique to chronic institutions should be borne in mind. In general, there is a high incidence of incontinence among the chronically ill, the infirm and the aged. In those instances where fairly complete utility room setups are provided, equipment will also be required for the handling of many bedpans and urinals and a large amount of soiled linen. Often the bedpan and urinal load and the soiled linen may overwhelm the "clean" area by sheer volume. Why not plan on a separate room for the bedpan hopper, bedpan cart, prewash sink and soiled linen storage?

GENERAL CONSIDERATIONS

Door Widths. All doors through which wheel-chair patients or inexperienced patients on crutches will have to pass should be good and wide. No such doors should be less than 3 feet wide and they ought to be as much as 3 feet 8 inches wide if there is the possibility that beds may be moved through them.

Ramps. It is true that a person in a wheel chair can negotiate a reasonable ramp. However, planning should provide for the marginal cases. Some of the chairfast have the use of only one limb. Such persons, and many less handicapped, operate their chairs with "very little to spare." Ramps should be avoided where possible. A chair rolling uncontrolled down even a relatively low ramp can be an instrument of death!

Drinking Fountains. Recessed drinking fountains often provided in hospials are not practical for wheel-chair patients on two counts. The recess is inaccessible for such patients and the valve is difficult for a person of limited muscular control to operate. Fountains for the use of patients should not be recessed; they should be of the continuous bubbler type. They are a nuisance around hospital corridors and could be much more easily maintained in the washroom.

Telephones. In urban areas the installation of telephones for the use of patients is of inestimable "morale" value for the long-term patient. It provides a link between the patient and the outside world. In the type of institution with which we are dealing the telephones must be so installed as to be accessible to the various types of patients. The standard type of wall coin phone may be so hung that the wheel-chair patient can use the phone at his side. This arrangement is convenient also for ambulant patients.

Finishes and Materials. Because of the activity of patients in wheel chairs and on crutches, the floors, walls, doors and trim of nursing homes will be subjected to unusually heavy wear. Materials that will stand up under such usage with a minimum of maintenance should be specified despite higher costs.

A durable and attractive wainscot should be provided for all interior wall surfaces for protection against damage by wheel chairs, stretchers and carts. The use of color for interior finishes and equipment is highly desirable. Paint used should have high qualities of durability and ease of cleaning and should be easily matched.

Floors and some equipment in patient areas will be subject to soiling by incontinent patients and should be carefully selected for their ability to withstand frequent cleaning and they should be of materials that do not retain odors.

Floor materials in areas used by patients must be slip-resisting. In dry areas a resilient floor material should be selected on the basis of its slip-resistant qualities and its resistance to permanent indentation resulting from concentrated loads of equipment. Heavy duty prepolished vinyl flooring has proved satisfactory for this use. A hard tile floor with slip-resisting surface may be specified for toilet and wet areas. Other finishes and materials should be similar to those recommended in general hospitals.





Rendering and floor plan of a 41 bed nursing home, with provision for future expansion. The one-story scheme eliminates the need for stairways and elevators and eases the movement of patients, staff, equipment and supplies.

(*Continued From Page 79*)

and therapeutic areas, of entrances and exits, particularly the main entrance, and substantial supervision of the service areas becomes necessary. It may be found expedient to have all of this control exercised from one point—a combination nurses' station, reception desk, and information center.

PATIENTS' SAFETY AND COMFORT

Special devices and arrangements must be incorporated into the design of nursing homes because of the physical condition of the patients. Many patients will suffer from the ills and infirmities attendant upon old age, and others will have chronic ailments which limit or change their previous mode of living. The safety, comfort and convenience of these patients must be provided for. It is important that the window sills in areas used by patients be low enough so that they do not interfere with the view of patients sitting in wheel chairs. In addition to the commonly required features of fire protection and sanitation, these homes should provide such things as slip-resistant floors, corridors 8 feet wide with handrails on both sides, handrails in water closet enclosures, baths and showers, and flush thresholds.

Stairways should be avoided if possible but when they must be used, they should not be less than 3 feet 8 inches between handrails, and should incorporate all recommended safety features. Steps or ramps, to take care of changes in floor elevation, or ramps from floor to floor, are hazards which should not be provided in nursing homes. Where elevators are necessary, their adaptability to wheel-chair transportation should be considered in selecting the size and number. Additionally, to facilitate patients' movements, sufficient space to accommodate wheel chairs should be allowed in dining rooms, recreation rooms, porches, toilets, baths, telephone booths, and the like. Doors to patients' bedrooms, treatment rooms, recreation rooms, and occupational activities rooms should be at least 3 feet 8 inches wide (3 feet 10 inches preferred). All other doors through which wheel chairs will pass should be at least 3 feet wide. Such furnishings as dressing tables, dining tables, worktables, desks, lavatories and drinking fountains should be designed for the accommodation of patients in wheel chairs.

ANCILLARY FACILITIES

Social contact and recreation are so much a part of making people feel emotionally secure and at home that facilities for those activities should be particularly well planned and should become the social and recreational hub of the nursing home.

Recreation — The recreation room should be as centrally located as possible with respect to the patients' bedrooms. Location near the lobby would be convenient for those patients who would enjoy viewing the activities in and around the main entrance and lobby. This would be convenient for visitors and in most cases for supervision by the nurses' station. The recreation room should be ample in scale, well lighted and decorated, and arranged to serve the recreational and occupational needs of the various patients. It should look out on scenes of interest and activity and, if possible, should have direct controlled access to outdoor recreational areas. There is no objection to the provision of more than one recreation room, but it is felt that generally the need for supervision and the pleasing effect of generous space makes one room preferable.

Occupational Therapy—Programs of occupational activities and rehabilitation would vary greatly in nursing homes and would affect the extent and arrangement of physical facilities to carry them out. It is probable that, in most homes, programs of occupational activities will not be extensive or require any heavy or specialized equipment and that they may be carried out expediently in the recreation room. If larger programs are contemplated, the necessary facilities would have to be programmed accordingly.

Dining—Patients' dining space can be provided in a separate room if the administration of the nursing home determines that this is most practical. However, since approximately 25 square feet per bed for 75 per cent of the total number of beds in the

nursing home is needed to accommodate diners in wheel chairs or needing assistance in walking, it is recommended that consideration be given to adding the dining space to the recreation space. This will make the dining area available for other purposes between meals, will add to the scale of the room, and perhaps make it more adequate for chapel services, movies and the like.

If the staff of the nursing home is large it probably will be expedient to provide a separate staff dining area. However, in the case of the small home with a minimum staff, this may be impractical and consideration should be given to the possibility of allowing the staff to use the same facilities as the patients, either jointly or on a shift arrangement.

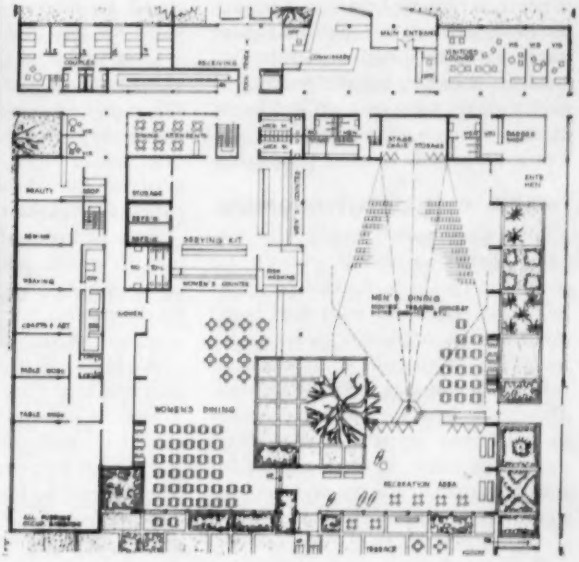
NURSING DEPARTMENT

The nursing department of the nursing home, because of its size and the necessity for making it compact to ease the nursing burden, will be the portion of the home which is in most danger of becoming institutional in look and character. The patients' bedrooms in the nursing department should approach as far as possible the domesticity of bedrooms at home and should afford all the amenities for intimate living and a haven when privacy is needed.

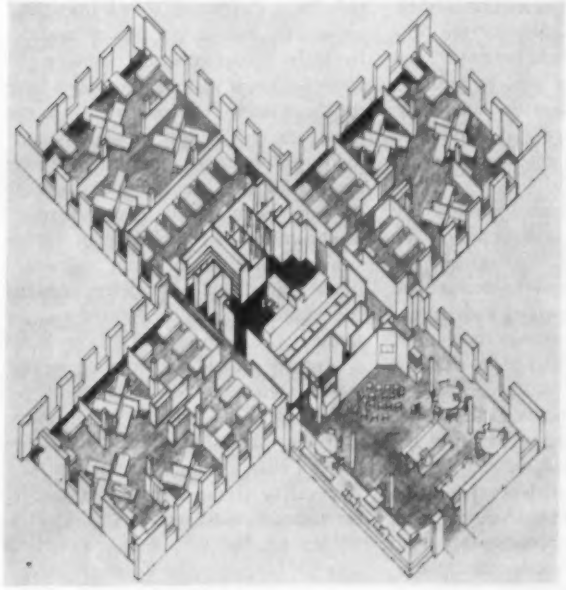
The nursing department should be located for ease of supervision and care by the nursing staff, ease of service from kitchen and storage areas, facility of movement between bedrooms and recreational areas, and for

THIS IS THE WAY A NURSING HOME SHOULD LOOK

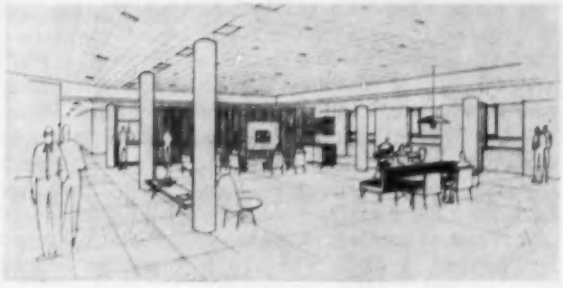




Above and right: Scale model and plot plan of the award-winning Riverview Extension for the Philadelphia Home for the Indigent, designed by Architects Gilboy, Bellante and Clauss. Eight detached pavilions, each serving 76 persons, are grouped around a central community building.



Left: Model of one of the 76 bed pavilions. Patients are housed in the three farthest wings, while the nearest one serves as a dayroom. The central core provides space for administrative offices. Below: Architect's sketch of a typical dayroom which leads into the main building.



the convenience of visitors to the patients. Orientation of the nursing unit should take into consideration not only the basic factors of light and air, but also those of view, patients' interests, and ease of access to outdoor areas.

The optimum size for a nursing unit in a nursing home, like that in a hospital, is about 25 to 30 beds. Forty beds are felt to be a maximum unless additional service facilities are provided. Consideration of such factors as the type, sex and physical condition of patients, the number of patients that personnel can supervise, and the length of the resulting nursing area will determine the proper size of nursing unit to give the quality and quantity of service the nursing home should give. Since a smaller percentage of patients in nursing homes will require intensive nursing care, the maximum travel to serve patients can be increased somewhat, but the distance of nurses' travel remains a critical factor in the efficiency of nursing care and should be kept as short as practicable.

TWO-BED ROOMS ARE ECONOMICAL

It is the general feeling that patients' bedrooms should contain no more than two beds. Careful programming will determine individual home needs for an occasional bedroom for four. No ideal ratio of one-bed or two-bed rooms has been established. Two-bed rooms are more economical to build and operate than one-bed rooms and some of these are needed for gregarious patients and for patients who should be placed in two-bed rooms as part of their treatment.

Patients' Bedrooms—Reference has already been made to the value of patients' bedrooms which are generous in size and homelike in atmosphere. They should be large enough to allow for movement of patients on wheel chairs, walkers or crutches, comfortable arrangement of furniture, and for some graciousness of living and entertainment of visitors. It is highly desirable that beds should be equitably placed in relation to windows.

In multiple bedrooms privacy must be provided by proper placement of screens or curtains. Curtains and tracks should be sturdy enough to support patients who occasionally hold on to the curtains to maintain their balance. Curtain tracks flush with the ceiling with provision for ventilation of the curtain at the top are preferred.

A minimum floor area of 100 square feet per bed in rooms with two or more beds and 125 square feet in one-bed rooms is desirable. Beds should be placed at least 4 feet apart and a minimum of 3 feet away from adjacent walls, wardrobes or other fixtures. Doors to patients' rooms should be at least 3 feet 8 inches (3 feet 10 inches preferred) and should swing into the room.

Patients' beds of the variable height type are recommended. Suitable devices should be used to prevent the movement of the bed while the patient is getting in or out or practicing bed exercises. The head board of the bed should be of the vertical rail type rather than flush. (By grasping the rails the patient is enabled to maneuver in the bed more easily.)

An overbed table and a standard enclosed bedside table should be provided for each bed.

Comfortable chairs should be provided for each patient and for visitors although they should not be so deep that patients would have difficulty getting out of them. Space should be available for wheel chairs while the patients are in their rooms.

Each bedroom should have a lavatory to encourage self-care and personal hygiene and for convenient use by the nursing home staff in care and treatment of the patient.

All lavatories should be set out on wall brackets 6 inches from the wall, 2 feet 10 inches above the floor, and should be wall connected to increase accessibility by patients in wheel chairs. They should be furnished with gooseneck supports and blade handle controls. Mirrors should be placed directly over the lavatories but may be angled downward slightly for the convenience of wheel-chair patients.

Fixtures which are used by patients should be supplied with hot water which is thermostatically controlled to provide a maximum water temperature of 110°F.

Since nursing home patients are long-term and are often up and active, indoors and out, for at least part of the time, they tend to accumulate more personal possessions and have a need for more clothing than most hospital patients do. To provide for these items ample storage space is required in the bedrooms. Locker space should be a minimum of 30 inches wide and 18 inches deep per patient. Clothes rods and shelves should be adjustable for the convenience of wheel-chair patients. Sliding doors with locks are desirable on lockers. Additional drawer and shelf space should be provided.

Nurses' Station—A nurses' station will be required for each nursing unit and should be located to conserve nurses' time and steps and to afford the most effective control of the nursing areas. Since it must also serve the other control functions recommended herein, it should be of approximately the same size as a station for general nursing. Equipment would vary with the institution but should include the minimum necessary for nurses' call, charting, medicine storage and preparation, and storage. The requirements for the nurses' call system are generally similar to those for a nurses' call system in a general hospital.

SERVICE DEPARTMENTS

Kitchen—The kitchen should be located so that it can easily serve either the patients' bedrooms or a central dining area and in such position that food delivery and garbage collection are convenient.

A dishwashing area should be provided separate from the kitchen and every precaution should be taken to prevent handling of soiled and clean dishes by the same person.

The kitchen layout and the provision of facilities and equipment, such as refrigeration, garbage disposal facilities, day storage, and ranges, should be based on the same standards as in a general hospital.

Laundry Facilities—Most nursing homes will probably decide to have their laundry done commercially. If this is done storage should be provided for clean and soiled linen and located for convenient pickup and delivery by the commercial laundry. In some homes, it may be feasible to have the clean linen delivered directly to the linen storage in the nursing department, but in most cases the necessity for sorting and the distance that the delivery men would have to travel might make this arrangement inconvenient. The size of clean and soiled linen rooms would be determined by the amount of linen to be used and the frequency of delivery and pickup. Some equipment should be provided to prewash linen used by incontinent patients before it is sent to the laundry.

If the nursing home administration decides that a laundry would be economical or if the commercial laundry services are not available, laundry facilities similar to those required in general hospitals should be provided.

Five Steps to Fire Safety

The helplessness of the majority of nursing home patients in the event of fire intensifies the need for adequate preventive and protective measures

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MUCH emphasis has been directed toward the betterment of fire safety practices in hospital buildings in recent years. It is time that an even greater emphasis be directed toward nursing home structures—a category of the medical care field which is due to receive a long and scrutinizing look. With an ever increasing emphasis on the need for nursing homes, and the beginning of a federally aided construction program to meet this need, it is important to consider the factors that affect the life safety of patients as well as those that contribute to their comfort and care.

To realize how serious this problem of fire safety in nursing homes can be, let us look at the kind of individuals who are sheltered in these institutions. Surveys in many states indicate that one-half or more of the patients in nursing homes are severely limited in their ability to walk. In this category are people who need wheel chairs, walkers or attendants' help, as well as those who cannot walk at all but must be carried. This excludes people who can walk with the aid of canes or crutches. In addition to the physical conditions described, these same studies show that at least 50 per cent of all patients are mentally confused for part or most of the time. This mental disorientation is present in many of the ambulant patients (see Fig. 1).

It becomes evident, then, that only a relatively few nursing home patients could fend for themselves in an emergency, such as a fire. The vast majority would need help in varying degrees, and it is the intent of this article to indicate how and where precautions should be taken to provide an adequate measure of fire safety in the nursing home.

Prepared under the direction of Dr. John W. Cronin, chief, Division of Hospital Facilities, Public Health Service, Department of Health, Education and Welfare.

PREVENTION AND PROTECTION

The basic principles of fire prevention and fire protection for nursing homes are essentially the same as for all other buildings, with only small variations in a few detailed requirements. To build and maintain a fire-safe structure, it is necessary to achieve the following five objectives:

1. Plan to minimize the chance of a fire's starting.
2. Plan for an early discovery of fire.
3. Confine fire and restrict its spread.
4. Provide means of extinguishment of fire.
5. Provide facilities for safe evacuation.

Let us examine in detail each of these basic measures listed, to see just how certain factors in the construction, maintenance and operation can be used to furnish a uniformly high degree of life safety from fire.

MINIMIZE CHANCE OF A FIRE STARTING

In order to know how to reduce the incidence of fires in nursing homes, it is necessary to review the causes of fires. The tabulation on page 86 lists the leading causes of fires in institutions and appropriate preventive measures which should be considered by each nursing home administrator.

EARLY DISCOVERY

It may seem elementary to say that almost all large fires start from small ones, but it is highly important to realize this fact. For this reason, the earlier a fire is discovered and the sooner extinguishing action is begun, the smaller the danger.

The nursing home differs from the hospital in that fewer staff employes are on duty in a nursing home, thereby lessening the opportunity to discover a fire in its incipiency. For buildings of a combustible nature, the use of automatic fire detection and alarm systems is essential.

There are several types of automatic fire alarm systems which could be used in nursing homes. These include: (1) automatic water sprinkler systems with waterflow alarm; (2) automatic chemical extinguishing systems with alarm; (3) heat activated fire alarm systems, and (4) smoke detection system.

Automatic water sprinklers or chemical extinguishing systems are especially desirable since they serve the threefold purpose of discovering the

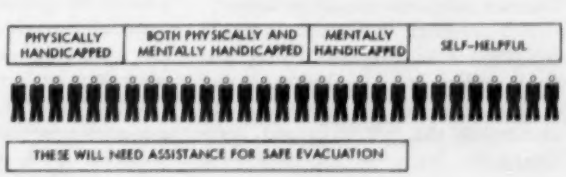


Fig. 1: Patient classification in nursing homes indicates the need for adequate safety measures.

CAUSE	PREVENTIVE MEASURES	CAUSE	PREVENTIVE MEASURES
SMOKING AND CARELESS USE OF MATCHES	Establish fair smoking regulations for personnel and patients. Delineate restricted or permissible areas if necessary. Provide adequate ash trays. Enforce smoking regulations. Use flameproofed materials for linens, draperies and bed clothing.	IMPROPER RUBBISH AND TRASH DISPOSAL FACILITIES	Provide large metal receptacles with covers for bulk storage of trash and collect trash and rubbish throughout building on a regular schedule. Do not permit trash to accumulate beyond the capacity of the containers, and remove all trash from the premises daily.
DEFECTIVE ELECTRIC WIRING	Review electric wiring systems, including switches and controls, for compliance with National Electrical Code. Make sure electric remodeling work is done in compliance with code requirements.	GREASES, OILS, CLEANING FLUIDS AND OTHER FLAMMABLE LIQUIDS	Dry-cleaning fluids should not be stored or used in nursing homes. Flammable paints and thinners should be stored in metal cabinets in fire-resistive rooms, preferably detached from the building housing patients. Use suitable exhaust hoods, fire-resistive construction, and carbon dioxide fire extinguishers to minimize grease fires at kitchen ranges.
BREAKDOWN OF ELECTRICAL AND HEATING EQUIPMENT	Follow manufacturers' instructions for installation and operation of all electrical and mechanical equipment. Establish a plan for regular inspection and maintenance, and correct all deficiencies as soon as discovered.	INCENDIARY CAUSES	Establish good administrative surveillance to control visitors and unauthorized traffic.
SPONTANEOUS IGNITION	Provide proper storage facilities for material subject to spontaneous ignition. Install automatic sprinkler system in such storage areas.	INADEQUATE PRECAUTIONS DURING REMODELING	Maintain adequate inspection and supervision of all construction work; follow safety recommendations of fire underwriters, factory mutual insurance companies or similar organizations.

fire, applying an extinguishing medium, and sounding an alarm.

It is important also that a municipal fire alarm street box be located in a prominent position adjacent to the main entrance of the nursing home for emergency use.

Large, many-winged or multistory institutions should be equipped with a local fire alarm system, which is an internal signaling system arranged to sound an alarm in one or more places in a building, primarily for the notification of occupants. If possible, the alarm system should be interconnected to transmit an alarm to the municipal fire department in order to eliminate any possible delay in notifying it. Details of acceptable alarm systems are obtainable from the local fire fighting authorities.

CONFINE FIRE AND RESTRICT SPREAD

The most comprehensive fire prevention measures will not eliminate the human element—the major factor in accidental fires. To control such accidental fires in time to prevent a major catastrophe, a number of preliminary measures should be taken.

If a fire starts in a room, it should be possible to keep it within that room until it burns itself out or until it is discovered and put out. To accomplish this, all walls and floors should be built of noncombustible materials. Concealed spaces behind finish materials or within the wall construction should be suitably blocked and fire-stopped to preclude the passage of smoke and gases from one room to another, or from one floor to another.

Openings through walls and floors should receive particular attention. Metal door frames are widely used in today's institutional buildings and are highly desirable for fire safety. Wood doors, if of heavy or solid core construction, are suitable for all patients' rooms and other locations where fire doors are not specifically required. The use of louvered panels and ventilating transoms in interior doors should not be permitted since they would allow the passage of smoke and flames out of a room.

It may not be possible to confine all fires to an individual room or other small area before they are controlled by organized fire fighting services, so it is recommended further that the designer subdivide each floor into at least two compartments or separate areas. This can be readily accomplished by providing a fire-resistive partition extending across the building from side wall to side wall and from floor to floor.

Where these transverse barriers cut across corridors, a pair of close fitting fire doors of the automatic type should be installed (see definition of automatic fire door). At least one such

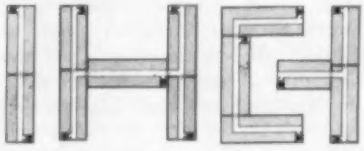


Fig. 2: How compartmentation is used to restrict spread of fire and to aid in evacuation of patients from building.

fire-resistive partition should be used at each floor level of every small building; additional ones should be used for larger buildings so that their spacing would be not more than 100 feet apart. Figure 2 indicates how various typical building layouts can be divided into convenient compartments.

In addition to the hazards arising from fire itself, there is perhaps as great a danger from asphyxiation on floors considerably removed from the floor on which the fire occurs. Many lives have been lost this way. To isolate each story effectively from the danger of fire, smoke or gases which may originate in another story, it is important to enclose all stairways, elevator shafts, dumb-waiters, and ventilating shafts in properly constructed fire-resistive walls.

Openings into these enclosures should be protected by approved

doors of the self-closing or automatic closing type. Similarly, fire-stopping should be provided to cut off all concealed draft openings (both vertical and horizontal) and to form an effective fire and smoke barrier between stories and between a top story and the roof space. The following specific locations should be carefully detailed to provide adequate fire-stopping measures:

1. At floor and ceiling levels of all stud walls.
2. In furred masonry walls.
3. Around all edges of sliding door pockets.
4. At holes in walls, floors and ceilings where pipes and pipe shafts pass through.
5. Space between suspended ceiling and structural floor or roof construction above.

Fire doors are especially designed to resist the passage of fire through the openings in the walls or partitions in which they are installed. They have been classified according to the degree of protection necessary, according to the character and location of the wall.

Class A openings are in division walls separating buildings, or a single building, into important fire areas. Doors protecting such openings are generally required on both sides of the wall.

Class B openings are in enclosures to vertical communications through buildings (stairs, elevators, hatchways), and in walls isolating areas of great hazard from the nursing home proper. Doors protecting such openings are required on one side of the wall only.

Class C openings are in corridor and room partitions.

Class D, E and F openings are those in exterior walls which have severe, moderate or light exposure, respectively, from outside the buildings.

Several types of fire doors are available for each of the classifications listed. Care should be taken in selecting the type of door acceptable for each location and, if possible, the consultation service of the inspection department having jurisdiction should be used. Doors should be labeled or otherwise shown to meet the standard requirements for the various classifications of openings.

Fire doors on openings which are used as a means of exit should be of the swinging type, and should open in the direction of exit travel in such a manner as not to obstruct the passage or the operation of other doors.

Properly installed swinging doors are easier to operate, especially under emergency conditions, than any other type and offer less resistance to rapid and emergency egress. These doors should be self-closing or automatic types. A self-closing door is one which is normally kept closed by some mechanical device. An automatic door is one which is normally kept open and is arranged to close automatically when released by the action of the heat or can be readily closed by manual controls.

Fire doors should be mounted on a labeled door frame and equipped with labeled hardware.

EXTINGUISHMENT OF FIRE

A fire extinguisher is designed to cope with fire at an early stage. The architect should specify the sizes and types of portable extinguishers required, and indicate on the drawings just where each should be located in order to be ready for immediate use.

Several types of fire extinguishers are available, but all are not equally effective upon different kinds of fires. Thus, consideration should be given to the kinds of fires which might occur in the various areas of the nursing home and to the proper type of extinguishers required.

Three general classes of fires have been established:

Class A fires may be defined as fires in ordinary combustible materials (wood, paper, fabric) where the quenching and cooling effects of water, or solutions containing large proportions of water, are of first importance.

Class B fires may be defined as fires in flammable liquids and greases (oils, gasoline, paint) where a blanketing effect to suppress combustion does the most good.

Class C fires are fires in electric equipment (motors, controls, panels, wiring) where the use of a nonconducting extinguishing agent is of major importance.

Fire extinguishers should be located so that a person will not have to travel more than 100 feet from any

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Sprinklers Are a Liquid Asset

GEORGE E. LINNEY

Administrator, Americus and Sumter County Hospital, Americus, Ga.

STATISTICS compiled by the National Fire Protection Association, the National Board of Fire Underwriters, and other major authorities based on reports from local and state fire protection agencies indicate that where an automatic sprinkler system is in satisfactory operating condition there has never been a major loss of life or property by fire. I emphasize the phrase, "satisfactory operating condition," because some time ago a two-story department store in Newark, N.J., was totally destroyed by fire with an estimated loss by the manager of the store of $2,000,000. This fire, one of the worst in the history of the city of Newark, might have been far less destructive if the sprinkler system which covered a part of the building had not been out of commission. This system had been turned off years ago and was inoperative at the time of the disaster.

We in the hospital business are primarily concerned with saving lives. Secondarily we are concerned with saving our material property, maintaining it in the best possible condition, and preventing any loss of time or revenue which can be sustained from a major catastrophe such as fire.

In connection with our primary purpose the figures on page 134 from the records of the National Fire Protection Association for a period of 10 years from 1935 to 1945 are conclusive evidence of the value of sprinkler systems.

(*Continued on Page* 134)

Condensed from a paper presented at the Southeastern Hospital Conference, Atlanta, Ga., 1954.

At the time this article was prepared, Mr. Linney was assistant administrator of Georgia Baptist Hospital, Atlanta.

point to reach the nearest unit, and at least one unit should be required for each 5000 square feet of floor area. Additional units of suitable types may be required for protection against special hazards.

The usual requirement for mounting fire extinguishers states ". . . shall be hung on hangers or set on brackets or shelves so that the top of the extinguisher is not more than 5 feet above the floor."

Because the weight of the unit (about 35 pounds each for 2½ gallon water type, or 10 pound CO_2 type) may make it difficult for a nurse to remove it from the wall when hung at the maximum height listed here, some authorities suggest that such an extinguisher be located as low as possible on the wall. If this suggestion is followed the extinguishers should be mounted on the wall so that the bottom of the extinguisher is located about 1 foot above the floor to permit uninterrupted operation of the floor cleaning and waxing machines.

EXITS

Among the leading causes of loss of life in institutional fires is the lack of sufficient and adequate exit facilities. When the fire persists, it may be necessary to remove patients who are endangered. Proper exit facilities should be available to expedite rapid evacuation.

There is one factor which complicates the evacuation problem in nursing homes. Because many patients are physically incapacitated, normal evacuation methods would be very slow. It is believed by many authorities that proper compartmentation of the building will aid rapid evacuation from the scene of fire.

The principle of compartmentation applied to building offers a simple and effective means of providing a high degree of safety to the occupants in case of fire. Compartmentation simply means the division of a floor area into two or more subareas by the use of transverse fire-resistive partitions.

Here is how compartmentation simplifies and speeds up the evacuation process in a nursing home. Let us assume a fire originates in a patient's room. That patient is removed and the door to the room is closed to isolate the blaze. All patients within the compartment where the fire originated are evacuated to adjoining compartments. This can be done easily and quickly, since it involves only the horizontal movement of patients for a relatively short distance. They are now safe from immediate danger and may stay there until the fire is extinguished.

If the fire persists or shows signs of spreading, it may be desirable to remove the patients to a lower floor or to a place of refuge outside the building. Then, with the patients in the safe compartment and out of immediate danger, a longer time would be available for an orderly evacuation either by elevator, if it is available, or else down the stairs and out of the building.

As mentioned earlier, each floor housing patients should be divided into at least two compartments. The number of compartments would depend upon the size and layout of the individual building. The exact length of each compartment would depend on the conditions which affect the time necessary to evacuate the area, but should be approximately 100 feet.

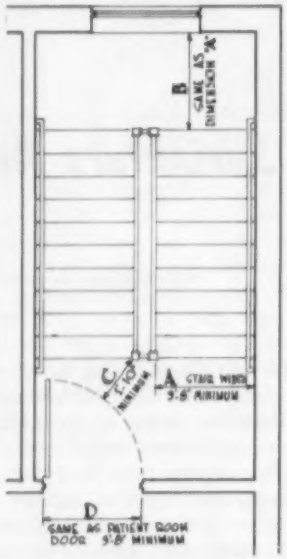


Fig. 3: Recommended dimensions for exit stairways to permit evacuation of patients on either stretcher or mattress.

Another important feature is the exit stairway. Figure 3 shows the pertinent dimensions in plan of a typical stairway which will permit evacuation by stretcher or mattress. There should be one stairway in each compartment to facilitate evacuation from one floor to another. It is not desirable to move patients laterally through one or several compartments in order to reach an exit stairway. There should also be a stairway located at the end of each corridor so that there are no pockets or dead ends in which occupants may be trapped. For one-story buildings, an exit should be used at the end of each corridor.

Exit stairways preferably should discharge directly to the outside or they may lead into a safe corridor on the first floor which in turn would have convenient access to an exit doorway leading to the street.

Exit stairways perform an additional function which is sometimes overlooked. They serve as a means of access for firemen, permitting them to fight an interior fire from close quarters within the building as well as by the customary use of outside ladders.

A corridor width of 8 feet is recommended for nursing home structures to accommodate the stretcher, bed and cart traffic within the building. This dimension is ample for evacuation requirements.

All exit door openings should have a minimum clear width of 44 inches to permit the evacuation of patients on beds, stretchers or mattresses. Doors should be arranged to swing in the direction of exit travel. Exterior doors should be arranged to swing outward.

Exit doors and passageways should have illuminated signs visible from the exit approach indicating the way of egress. Local codes and regulations generally cover the size, type and construction of these signs.

CONCLUSION

There is no royal path or short-cut to the goal of adequate fire safety in nursing homes. Each structure should be evaluated on an individual basis and all five measures—minimizing the fire risk, planning for early discovery, confinement, providing a ready means of extinguishment, and providing evacuation facilities—must be equitably considered. Neglecting one of these features could seriously weaken the chain of fire safety. Similarly, overemphasizing one of the features at the expense of the others would be economically unwise. It is hoped that the designers of new institutions and the administrators of existing ones will seriously consider the patients' safety from fire as one of the important functional requirements for nursing homes.

Administrators


George H. Buck

George H. Buck, director of University Hospital, University of Maryland, Baltimore, has become administrator of Nassau Hospital, Mineola, N.Y., succeeding **Carl I. Flath.** Mr. Buck is a graduate of the course in hospital administration at the University of Chicago. He served as assistant superintendent of Lenox Hill Hospital, New York, and Long Island College Hospital, Brooklyn, N.Y., and later became superintendent of Mercer Hospital, Trenton, N.J. Mr. Buck has been chairman of the joint commission on operating room explosion hazards of the American Hospital Association and is a member of the American College of Hospital Administrators and of the New Jersey Hospital Association.


Wilbur C. Anderson

Wilbur C. Anderson, formerly administrative assistant to the executive secretary of the Delaware State Board of Health, Wilmington, has been appointed executive director of Emily P. Bissell Sanatorium, Wilmington. Mr. Anderson has been acting director since February. He received his M.P.H. degree from Johns Hopkins University and is a member of the American College of Hospital Administrators.


Edward C. Ackerman

Edward C. Ackerman, administrative assistant, Binghamton City Hospital, Binghamton, N.Y., has assumed his duties as assistant administrator there. Mr. Ackerman is a graduate of the course in hospital administration at Johns Hopkins University School of Hygiene and Public Health and served as administrative intern at Mary Imogene Bassett Hospital, Cooperstown, N.Y. He is a member of the American Hospital Association and a nominee of the American College of Hospital Administrators.

Ralph W. Nelson, administrator of Portland Sanitarium and Hospital, Portland, Ore., since 1917, has resigned. Mr. Nelson has served three terms as president of the Oregon Association of Hospitals and is secretary of Northwest Hospital Service. He is a former vice president of the Association of Western Hospitals.

Dr. Peter A. Volpe, manager of Veterans Administration Hospital, Hines, Ill., has been named administrator of University Hospital, Ohio State University Health Center, Columbus. He succeeds **J. Milo Anderson,** who became administrator of Strong Memorial Hospital, Rochester, N.Y., earlier this year. Previous to his appointment at Hines, Dr. Volpe had been manager of Veterans Administration hospitals at Dwight, Ill., and Aspinwall, Pa.


Joseph P. Greer

Joseph P. Greer, assistant director of North Carolina Memorial Hospital, Chapel Hill, N.C., since 1951, has been appointed assistant director in charge of future development and planning, St. Luke's Hospital, Chicago. Mr. Greer is a graduate of the school of hospital administration at the University of Chicago.

James Kenney, a graduate of the course in hospital administration at the State University of Iowa, has been appointed assistant administrator of Mary Lanning Hospital, Hastings, Neb.


Robert W. Holters

Robert W. Holters, administrative assistant of Perth Amboy General Hospital, Perth Amboy, N.J., for the last three years, has become assistant administrator of Jefferson-Hillman Hospital, Birmingham, Ala. Mr. Holters was graduated from the course in hospital administration at St. Louis University and is a member of the American College of Hospital Administrators and the Alabama Hospital Association.

Don C. Carner has resigned as administrator of Parkview Hospital, Fort Wayne, Ind., to accept the position of administrator of Seaside Memorial Hospital, Long Beach, Calif. Mr. Carner will be succeeded at Parkview by his assistant, **Stanley R. Nelson.**

Paul Meyer Jr., administrator of Bradford Hospital, Bradford, Pa., has announced his resignation.


Erwin J. Remboldt

Erwin J. Remboldt, who has served in the business office of White Memorial Hospital, Los Angeles, has been appointed administrator there. Mr. Remboldt will receive his master's degree in business administration with a specialty in hospital management from the University of Chicago in June.

Alexander L. Babbitt, president of the board of trustees of Tacoma General Hospital, Tacoma, Wash., and retired banker in Tacoma, has become director of General Hospital, succeeding the late **W. John Dobyns.** Mr. Babbitt resigned as president of the board to accept the administrative post.


John A. Holbrook

John A. Holbrook has been named assistant director, physical plant, of Presbyterian Hospital, Chicago. Mr. Holbrook succeeds **Philip Seeskin,** who has resigned. A graduate of the University of Iowa, Mr. Holbrook is a member of the American Society of Heating and Ventilating Engineers and the Cleveland Society of Professional Engineers. He was formerly a sales engineer in Cleveland.

Sister Bonosa, administrator of Providence Hospital, Oakland, Calif., has been named administrator of St. Mary's Hospital, Walla Walla, Wash., succeeding **Sister Joseph of Arimathea.**

(*Continued on Page* 184)

The Best "Buy" in Parenteral Solutions?

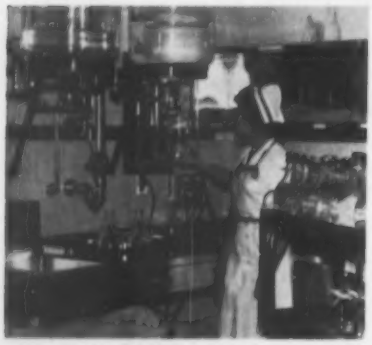
1—"Hospital Preparation Is Most Economical"

SIDNEY LISWOOD
Administrator, The New Mount Sinai Hospital, Toronto, Ont.

NORMAN S. FINER
Administrative Director, Jewish Hospital Association, Cincinnati



Nurse's aide washing flasks.



Manufacturing solutions.



Autoclaving solutions.

WE AT Beth Israel Hospital, Boston, had been interested for some time in determining the cost of preparing parenteral solutions. We believed that savings existed but no one knew how great these were nor could we compare with any degree of accuracy the cost of manufacturing 1500 cc. of 2½ per cent dextrose in water, for example, with the cost of purchasing a similar solution. When the manufacture of solutions by the hospital was challenged as being financially unsound, a cost study was initiated to determine whether or not it was less expensive, and if so how much.

The supervisor of the central supply room, Mrs. Helen Jeffrey, was approached concerning the cost study* and her cooperation was obtained because she too was interested in this subject. It was decided that the number of flasks requisitioned would be considered the number manufactured during 1952, inasmuch as figures had been collated monthly from the requisition sheets. On an annual basis the amount produced would closely approximate the number requisitioned, since more than 50,000 flasks were consumed annually. In addition, the inventory at the beginning and end of the fiscal year 1952 was not considered in the statistical analysis because one can assume that it was necessary to have a certain number of flasks of solution on hand each year to meet requisition demands.

The cost study was also based on the premise that certain costs could not be avoided despite the purchase of parenteral solutions. For example, the cost of the labor involved in the distribution of a flask or the storage space needed would not be eliminated upon purchasing commercially. Therefore, these factors were not considered. However, the cost of washing flasks and autoclaving solutions is a direct expense and was accordingly considered in the expense distribution.

The cost study involved four steps for completion:

1. A preliminary cost sheet for all items of expense broken down into eight categories:
   - Ingredients
   - Water (both tap water and distilled water)
   - Fuel (steam)
   - Nonbreakable materials
   - Replacements or repairs to equipment
   - Replacement due to breakage, addition to inventory, and so on
   - Depreciation on equipment
   - Labor (personnel, repairs, administration)
2. A cost sheet summarizing all items of expense.
3. A cost sheet of the distribution factors (a weighting process) for all items of expense.
4. A production cost sheet.

The distribution expense cards for the central supply room carry the name of the vendor, the date, items purchased, and the amount of the invoice. Since the expense distribution cards for the central supply room contain items totally unrelated to solution manufacture, all invoices had to be reviewed. After all invoices

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At the time this article was prepared Mr. Liswood was associate administrator of Beth Israel Hospital, Boston, and Mr. Finer was the administrative resident.

*The cost study was patterned after the cost analysis done at Brooklyn Jewish Hospital in 1950.

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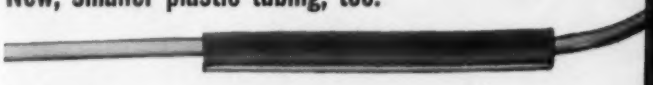


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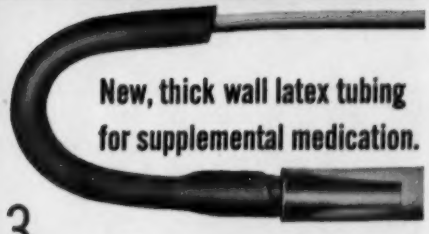
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were screened, the supervisor of the central supply room checked the preliminary cost sheet for accuracy. All items of expense were then summarized and the collated figures were transferred to the summary cost sheet. Distribution factors were computed on the basis of volume, concentration and production. This was actually a weighting process. The product of the distribution factor and the cost for each category of expense resulted in the fractional cost for each solution. The sum of the fractional costs divided by the requisition figure produced the cost of each flask of solution.

STEP NO. 1

Step No. 1 was the foundation on which succeeding steps were based and therefore meticulous care and judgment were exercised in the calculation of the basic cost figures.

Ingredients. The amounts purchased and the cost of the various ingredients used in solution manufacture were obtained from the hospital's purchase records and from the pharmacy.

Water (tap water and distilled). The actual cost was determined by computing the volume of distilled water of total production, multiplying by 6 to include tap water consumption, and converting the volume to gallons. This, plus an estimation of the amount consumed by washing, represented total water consumption for solution manufacture. Upon comparing this figure with hospital water consumption, an estimation of water cost was made.

Fuel (steam). After the supervisor of the central supply room made a time study of the daily utilization of the autoclaves and stills, manufacturers' representatives were consulted concerning steam consumption per hour and per operation. The steam cost which included labor, maintenance, repairs and so forth, was obtained from the annual report of the maintenance department. From the data obtained, annual steam consumption and costs were calculated.

Materials, replacements and repairs. The cost of nonbreakable materials such as stoppers, bushings and solution identification tags, the cost of repairs to equipment such as synthetic rubber gaskets and cleanout plugs, and the cost resulting from breakage or additions to inventory were obtained from the invoices.

Depreciation on equipment. The cost of original equipment was obtained from the purchase orders. The cost of such equipment as shelving, sinks and cabinets was obtained from the contractors. All the equipment except the autoclaves were depreciated on the basis of a 10 year life. From the time study of autoclave utilization, data were obtained which indicated that the autoclaves used one-third of the total time for solution manufacture. Therefore, in the allocation for depreciation of autoclaves, only one-third of 10 per cent of the initial cost was considered as the expense to be weighted and distributed.

Labor. One person is employed full time in the solution room while another spends approximately one-half of her time washing flasks and other materials necessary for solution manufacture. The cost of housekeeping, pharmacy and maintenance was obtained directly from the monthly reports submitted by these departments.

The cost of supervision was computed by multiplying the percentage of personnel under supervision by the salary of the supervisor of the central supply room. Similarly, in apportioning administrative expense to solution manufacture, the determining factor was the number of personnel involved.

STEP NO. 2

The various items of expense were transferred to the summary cost sheet which showed the totals of each item purchased. For example, the preliminary cost sheets showed that purchases of a certain number of pounds of dextrose were made at different intervals during the fiscal year while the summary cost sheets showed that a total of 2800 pounds of dextrose was purchased. The summary cost sheets were totaled to indicate total costs for each category of expense, *i.e.* total cost of labor, steam, water, nonbreakable materials.

STEP NO. 3

The computation of the "distribution factors" was based on three variable factors: (1) per cent concentration; (2) volume, and (3) production. The type of solution of specific concentration, volume and production was listed horizontally on the work sheets; categories of costs were listed vertically.

Ingredients. To determine the fractional production cost of dextrose of specific concentration and volume, let us consider 1000 flasks of 2.5 per cent dextrose in 1500 cc. of water. The cost is actually dependent upon the three variable factors. The multiplication of the per cent of concentration, the volume of the flask and the production figure will yield the "distribution units." After this was done for the various solutions containing dextrose, the distribution units were totaled. The distribution units of 1000 flasks of 2.5 per cent dextrose in 1500 cc. of water divided by the total of the distribution units will yield the fractional cost which had been labeled "distribution factor." This procedure produced fractional costs for ingredients.

Water. The amount of water used in the manufacture of parenteral solutions is directly proportional to the volume of the flask and production and is independent of concentration. Therefore, the product of volume and production will yield the distribution units. The distribution units of each solution divided by the total of the distribution units will produce the distribution factor.

Steam. The distribution factors for steam were identical to those of water, since the use of steam is directly proportional to the volume of the flasks and production only.

Nonbreakable materials, replacements, depreciation and labor. The costs of nonbreakable materials, repairs, replacements, depreciation and labor were weighted on the basis of production only since these costs are unrelated to volume and per cent of concentration. The production figure of a specific solution divided by total production will yield the distribution factor.

STEP NO. 4

The final cost sheet bore the categories of expense and total costs vertically and the distribution factors of a specific solution horizontally. To compute the cost of dextrose in 1000



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flasks of 2.5 per cent dextrose in 1500 cc. of water, the distribution factor was multiplied by the total cost of dextrose purchased in 1952. This procedure was followed for each category of expense. The sum of each fractional production cost will yield the total production cost. And dividing the production cost by the production record will yield the cost per flask of solution of specific concentration and volume.

FINDINGS AND CONCLUSIONS

1. The cost of solution manufacture in the central supply room averaged $0.2661 per flask.

2. In manufacturing the solutions ourselves, the maximum difference in cost between a flask containing 500 cc. and one containing 1500 cc. of solution was $0.04, whereas this difference would have been approximately $0.84 had we purchased these solutions.

3. If solutions were purchased commercially, approximately $50,000 would have been spent. Total cost of solution manufacture in the central supply room was slightly less than $14,000, a saving of $36,000.

4. The installation of the original equipment, including the autoclaves, was less than $20,000, an investment which has more than paid for itself in less than a year.

5. The largest items of expense were labor and replacements owing to breakage, losses and additions to inventory, with labor representing 45 per cent of the total expense and replacements, 25 per cent.

6. A total of 35 different solutions was manufactured in the central supply room with production figures running from a minimum of four flasks to a maximum of 11,901. It is therefore indicative that there is flexibility in manufacture and that the means can be devised to prepare solutions not being currently prepared in the solution room. In addition, it may be inconvenient or burdensome to purchase four, six, eight or 12 flasks of a specific solution commercially whereas such solutions can easily be made within a short period of time.

7. If solutions were purchased commercially for a three-month period, approximately 12,000 flasks (in cartons) would be purchased, requiring much more storage space, handling and paper work. Currently, there is a daily control and a daily replenishment of solutions for stock. Even if purchases were made to meet monthly needs, 4000 flasks packed in cartons would still mean more storage space, handling and paper work than daily replenishment.

8. Preparing parenteral solutions in the central supply room is quite convenient and highly advantageous as far as patient care is concerned. There is no need to buy one or two cases of a solution which is rarely used. It is relatively easy and economical to prepare a limited number of special solutions of a certain volume and concentration which are not commonly used, and the solution can be ready for administration in a short time. In addition, since production costs are so low, charges to patients are kept at a minimum.

9. Parenteral solutions should be analyzed quantitatively, qualitatively and bacteriologically at frequent intervals in order to ensure the accuracy of chemical purity and to control possible contamination.

10. It is imperative that cleanliness and asepsis prevail not only in relation to solution manufacture but also with respect to storage.

2—"We Buy Our Solutions to Save Work and Worry"

SHERMAN W. MORRISON
Director of Pharmacy
Wesley Memorial Hospital, Chicago

WHEN intravenous fluids were first introduced, they were prepared in hospitals, in many cases, with inadequate equipment and facilities which resulted in febrile reactions among patients. Difficulties were encountered in obtaining pyrogen-free water and in cleaning the rubber tubing of the administration sets. As better equipment was obtained and the technics and procedures improved, reactions from solutions became less frequent and now they rarely occur.

From the beginning, manufacturers of parenteral solutions cooperated with the hospitals in developing the most suitable containers, sets for the administration, and combinations of solutions desired. Today, manufacturers are better prepared to make good intravenous solutions than is the average hospital. The manufacturers, with their fine equipment, meticulously clean rooms, and trained personnel, carefully check all materials purchased, maintain close supervision of every step in the preparation, and assay every batch for accuracy of content. Laboratory tests are made for sterility and rabbits are tested for pyrogens in order to meet the rigid standards that are required for all intravenous solutions. For these reasons the medical staffs of many institutions prefer to obtain solutions from commercial sources. They are of the opinion that it is not worth the work and worry for the hospital to make its own intravenous solutions.

No pharmacist or physician will use intravenous solutions unless they are known to be safe and until every precaution has been taken to assure the highest quality. This means that laboratory tests must be made on every batch prepared to determine sterility of solution and tests must be made on rabbits to ensure absence of pyrogens. Likewise, chemical assays must be made of all solutions. This requires additional space for such tests and for storage of the solutions until the rather expensive tests have been made before the solutions are released for use. These tests add greatly to the cost of the solutions and many hospitals are not well equipped to make them. Extra tech-

(*Continued on Page 96*)

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See page 116 Yearbook from Hospital Topics, Volume II

nicians, extra time, and extra space are important factors to consider in computing the cost of manufacture.

While the preparation of the solutions is really quite simple, it requires extra caution and care. The cleanliness of the equipment and the bottles is extremely important and it is often difficult to find and to hold competent help for this work. I know of several instances in which the manufacture of intravenous solutions has had to be discontinued because of the hospital's inability to find someone to do the work.

The manufacture of intravenous solutions requires additional space for the pharmacy. A specially designed, dust-free room for washing the bottles, preparation, sterilization and storage of the solutions is necessary. In our hospital, and in many others, space is at a premium and it is impossible to find space without taking it from the patient sections or other important areas. Cost of equipment is high and will absorb any savings made for the first two years, and additional maintenance must be included in the cost. Breakage of bottles and other glassware and replacement cost of stoppers and caps must be considered, as well as depreciation on the equipment and cost of materials, chemicals and reagents.

Salaries paid both to the people who actually make the solution and to those who do the sterilizing, inspecting and testing of the finished product must be included in the cost of solutions.

MUST ADD "HIDDEN COSTS"

There are many hidden costs to be added. The parenteral solution department must carry a portion of the costs of general administration, the accounting department, personnel, maintenance, insurance and general depreciation of the building. A share of the cost of heating, light, telephone service, laundry and janitor service must also be added to the cost of making intravenous solutions.

Many chemicals and combinations of them are required now for the proper treatment of patients. At Wesley Memorial Hospital, Chicago, approximately 31,000 bottles of various intravenous solutions are used annually at an average cost of 74 cents each. Twenty-six different solutions or sizes are stocked at Wesley to supply the needs of the physicians. This means that some are bought in small quantities or made in small batches if manufactured in the hospital. Small batches are much costlier to prepare than large batches are. Furthermore, it is not feasible to make intravenous protein hydrolysate solutions, so the containers purchased will require a different set for administration than does the container used by the hospital. Having two different types of containers and sets leads to confusion and errors in ordering by the nurses.

In making parenteral solutions, the manufacturer uses new glass bottles and stoppers, whereas, in the hospital, bottle caps and stoppers are used repeatedly. This introduces a hazard, as bacteria or mold may lodge in minute scratches or crevices and not be completely removed in the washing process, resulting in pyrogenic reactions.

It is conceded that the hospital that has proper equipment and trained personnel and that makes all the necessary tests to check the finished product can produce as good a solution as the manufacturer can but when all the expenses involved are considered, the difference in cost is not so great as would at first appear.

Absence of trained personnel may easily disrupt the hospital production program and create a hazardous situation. It takes just one serious or fatal reaction from a solution, resulting from inadequate testing or assay, to make the cost to the hospital in terms of damage suits, increased insurance premiums, and legal expense much greater than the saving that might accrue from making the solutions.

When all is considered, is it worth all the extra work, extra labor, cost of laboratory tests and equipment, and the risk of faulty solutions, with the uncertainty of obtaining experienced help, to save perhaps 30 to 40 cents per liter? We should never value the safety or welfare of our patients on the basis of dollars and cents and I do not believe that the slight additional cost per liter would be a hardship to the average patient or the hospital.

The use of commercial solutions relieves the hospital of legal and moral obligations which it must assume when it manufactures its own solutions, and additional overhead expenses are eliminated.

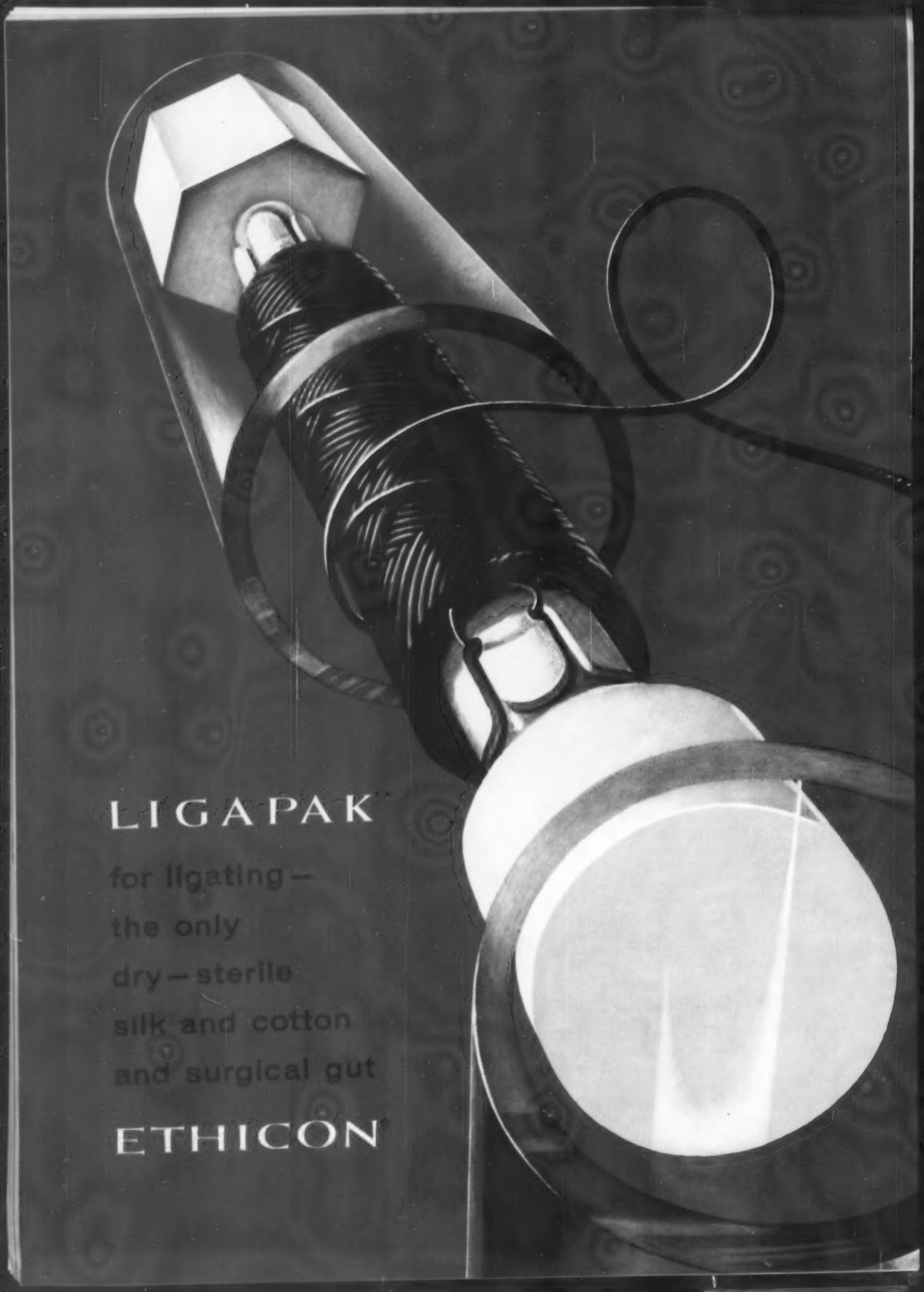
(For the third article in this group, see Page 98.)



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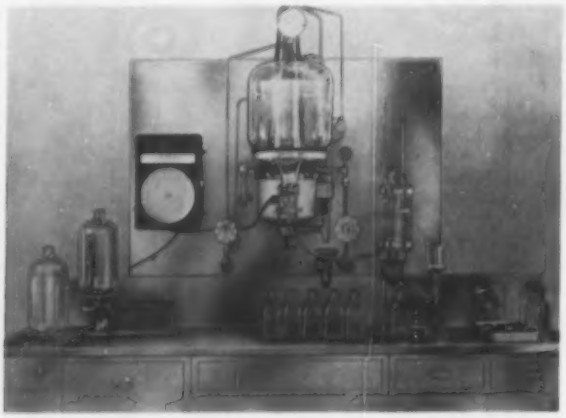
by A·S·R

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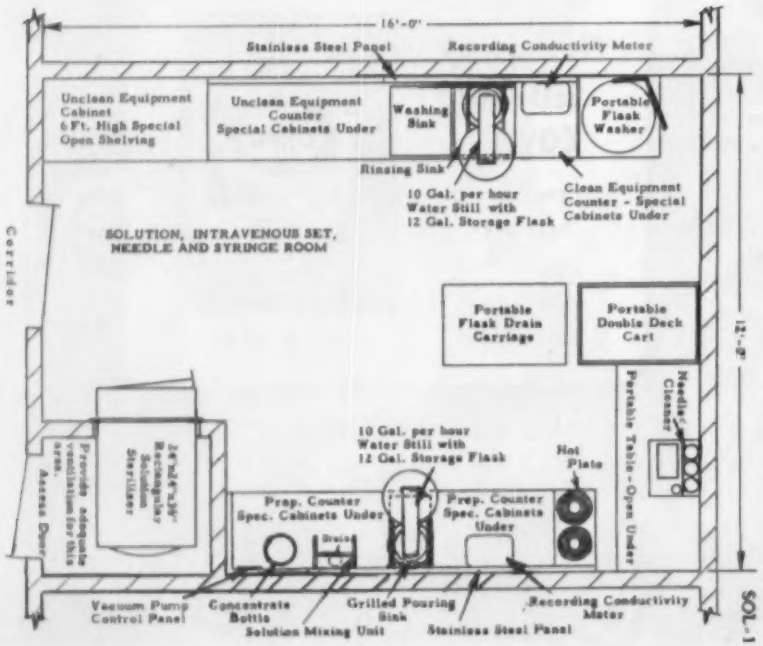
3—"If You Want to Cut Costs—Make Your Own"

E. W. MILLER
Director, Huron Road Hospital, East Cleveland, Ohio

ANY hospital of 100 beds or more is in a position to manufacture its own intravenous solutions, assuming that a pharmacist is available a few hours each week to supervise their preparation. In the past, the supervision of the preparation of parenteral solutions was too often assigned to someone who was not properly trained. Today, it is accepted procedure that the preparation of these solutions shall be directly supervised by the pharmacist. The pharmacist need not do the actual technical phase of the preparation, inasmuch as an intelligent lay person can do a very fine job with a minimum of supervision.



Left: The solution preparation unit. Below: Suggested plan of a solution room for a 100 bed hospital.



The pharmacy should be installed as part of, or immediately adjacent to, the pharmacy. In this location it can be completely staffed by pharmacy personnel. Prepared solutions need not be stored in the pharmacy but can be transferred to central supply or some other convenient area for distribution. Preparation of liter flasks represents the largest volume of production, of course, but, in addition, many small sterile extemporaneous solutions can also can be prepared, such as sterile procaine, small vials of sterile water, and other injectible items.

With modern equipment, the number of man-hours necessary to prepare intravenous solutions is unbelievably small. For example, the amount of time required in a 300 bed hospital to produce approximately 350 parenteral units per week would be five or six hours of an aide's time, nine to 10 hours of a technician's time, and three to four hours of supervision by the pharmacist. Smaller hospitals would reduce this amount of labor in proportion to their size.

Statistics show that commercially prepared solutions cost the average hospital approximately 65 cents per liter. The cost of the actual ingredients for an average liter flask is actually less than 2 cents per liter. These same solutions have been safely prepared in the hospital at an average total cost of 16 cents per liter. With proper supervision, they can be as safe and as pure as those purchased commercially, and will be more quickly available, thereby eliminating a large inventory of solutions.

By simple deduction, it should be evident that 75 per cent of the money spent in an institution for commercial solutions can be saved, making this an excellent means of cutting down hospital costs. There is probably no proce-

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Photo No. 1—Inhalation Completed. Photo No. 2—Exhalation Started. Photo No. 3—Exhalation Completed. Respiratory cycle is from Photo No. 1 to Photo No. 3 and back to Photo No. 1. Speed and angle of oscillation is regulated by controls on instrument attached to base of bed.

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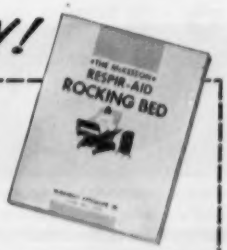
Because McKesson Respiraids are used in *all three of these ways*, most leading hospitals have found this equipment necessary for proper treatment of some of their patients.

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dure change in the entire hospital that could save as many dollars.

Once the average administrator is convinced he can make solutions in his own institution, he immediately becomes interested in the cost of equipment necessary for their preparation. This cost varies with the function assigned to the solution room. It must be understood that a properly designed solution room can include facilities for preparing irrigating solutions as well as the processing of syringes and needles.

When hospitals decide to process needles and syringes in this area, little additional equipment is necessary. A 200 bed hospital can set up a complete solution room for approximately $14,000, plus approximately $1500 for equipment to process syringes and needles. A 300 bed hospital would require the expenditure of approximately $16,000 for solution equipment, plus $1800 for needle and syringe processing.

It is safe to say that a well equipped laboratory for the preparation of solutions can be paid for with the savings of two years' purchase of commercial solutions. The initial cost of flasks would be considerably more than commercial flasks, but they are used many times over. When solutions are made within the institution, packaging, delivery and many other manufacturing costs can be eliminated. The hospital that depends on a commercial solution must provide large storage space to carry adequate stocks. With hospital-prepared solutions, sufficient quantities can be prepared for a normal consumption period. Consequently, warehouse and storage space do not constitute a major problem.

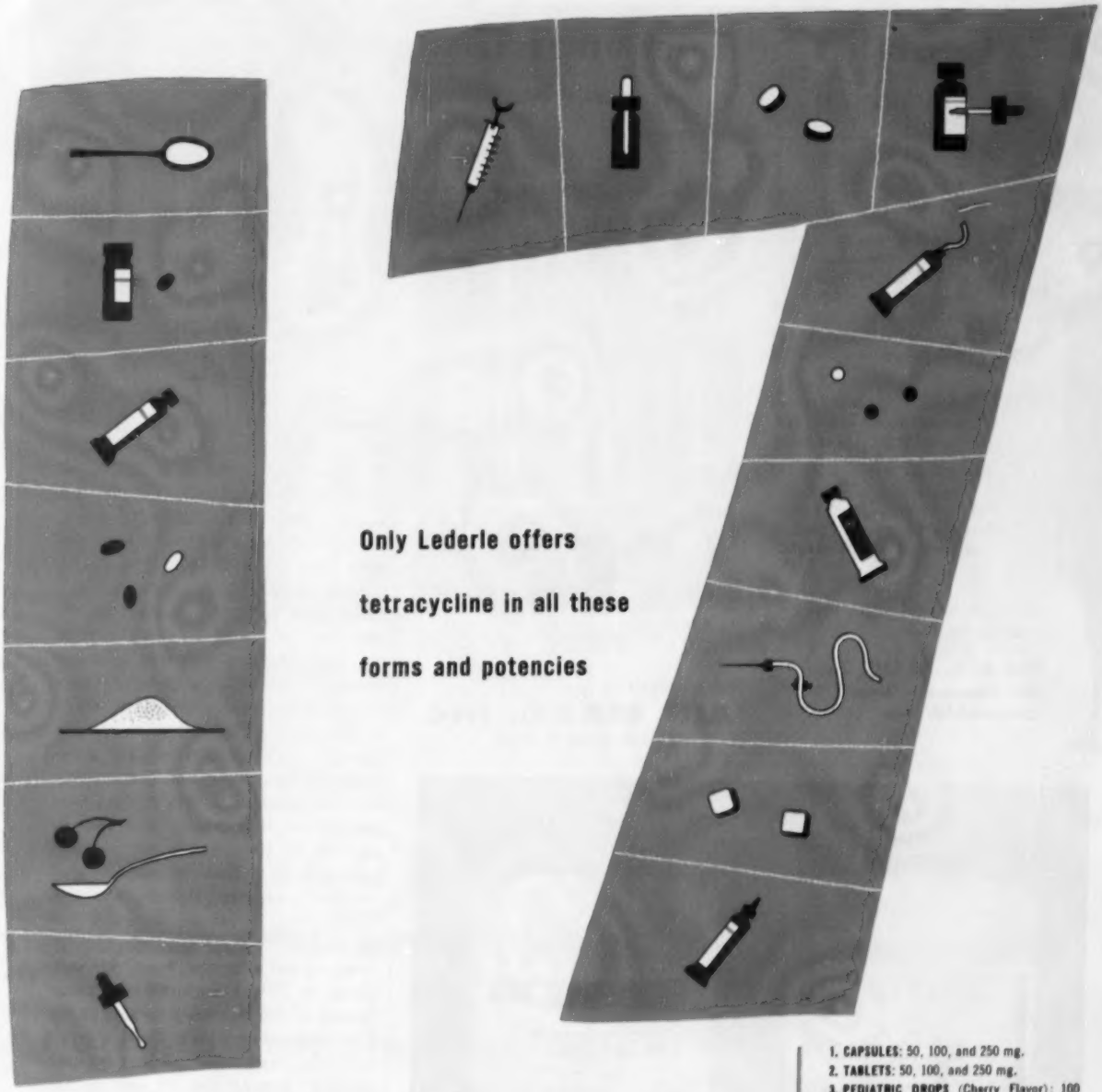
(*Continued on Page* 102)

LIST OF SOLUTION ROOM EQUIPMENT FOR PHARMACY IN A 150-250 BED HOSPITAL

Item	Quantity	Approx. Cost
Stainless metal clean-up counter 9 feet long, with wall panel; stainless metal preparation counter, 9 feet long, with wall panel; stainless metal control panel		$ 3939.00
Automatic flask washer and rinser	1	950.00
10 gal. per hr. stills @ $700 each	2	1400.00
Heat-resistant 12 gallon storage flasks, complete with wall brackets @ $75 each	2	150.00
Pair pressure regulating valves for steam and water supply lines @ $125 per pair	2	250.00
Automatic recording conductivity meters with special draw-off cocks for 12 gal. carboy @ $575	2	1150.00
Safety filler, complete, with two extra glass cylinders	1	675.00
Pressure vacuum pump	1	125.00
Metric solution balance	1	82.50
Drum (100 lbs.) detergent	1	16.25
Cartons 500ML flasks @ $20.40 per ctn. of 24	3	61.20
Cartons 1000ML flasks @ $22.80 per ctn. of 24	15	342.00
Cartons collars (synthetic rubber) @ $26.40 per ctn. of 48	9	237.60
Cartons covers (plastic) @ $26.40 per ctn. of 48	9	237.60
Cartons stainless metal solution identification tags @ $15.30 per ctn. of 48	9	137.70
Cartons stainless wire bails for 500ML flasks @ $3 per ctn. of 24	3	9.00
Cartons stainless wire bails for 1000ML flasks @ $3.50 per ctn. of 24	15	52.50
Flask tongs @ $7.50 each	4	30.00
Cartons disposable administration sets @ $55 per ctn. of 100 (Approx. 1 mo. supply)	7	385.00
Flask drain carriage @ $150 each	1	150.00
TOTAL		$10,380.35

OPTIONAL EQUIPMENT

Item	Quantity	Approx. Cost
Stainless metal portable double deck cart 24 by 36 by 36 inches high	1	$ 132.00
Stainless metal storage cabinet 4 feet long	1	433.00
Stainless metal portable worktable 2 feet x 5 feet long	1	333.00
Automatic needle cleaner	1	675.00
24 by 24 by 36 inch rectangular solution sterilizer, full nickel clad, recessed mounted	1	4060.00



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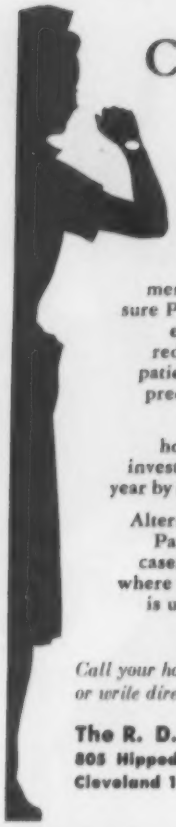
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8. **INTRAMUSCULAR**: vial of 100 mg.
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10. **OPHTHALMIC OINTMENT** (1%): ⅛ oz. tube
11. **OPHTHALMIC SOLUTION**: vial of 25 mg. with sterilized dropper vial
12. **EAR SOLUTION** (0.5%): 10 cc. dropper bottle
13. **SYRUP** (Cherry Flavor): 125 mg. per teaspoonful (5 cc.) 2 oz. bottle
14. **TROCHES** 15 mg. (Peppermint Flavor)
15. ***PHARYNGETS**** **Troches** 15 mg. (Cherry Flavor): box of 10 (foil wrapped)
16. **OINTMENT** (3%) **with HYDROCORTISONE** (2%): 5 Gm. tube
17. **OPHTHALMIC OINTMENT** (1%) **with HYDROCORTISONE** (1.5%): ⅛ oz. tube

*REG. U.S. PAT. OFF.



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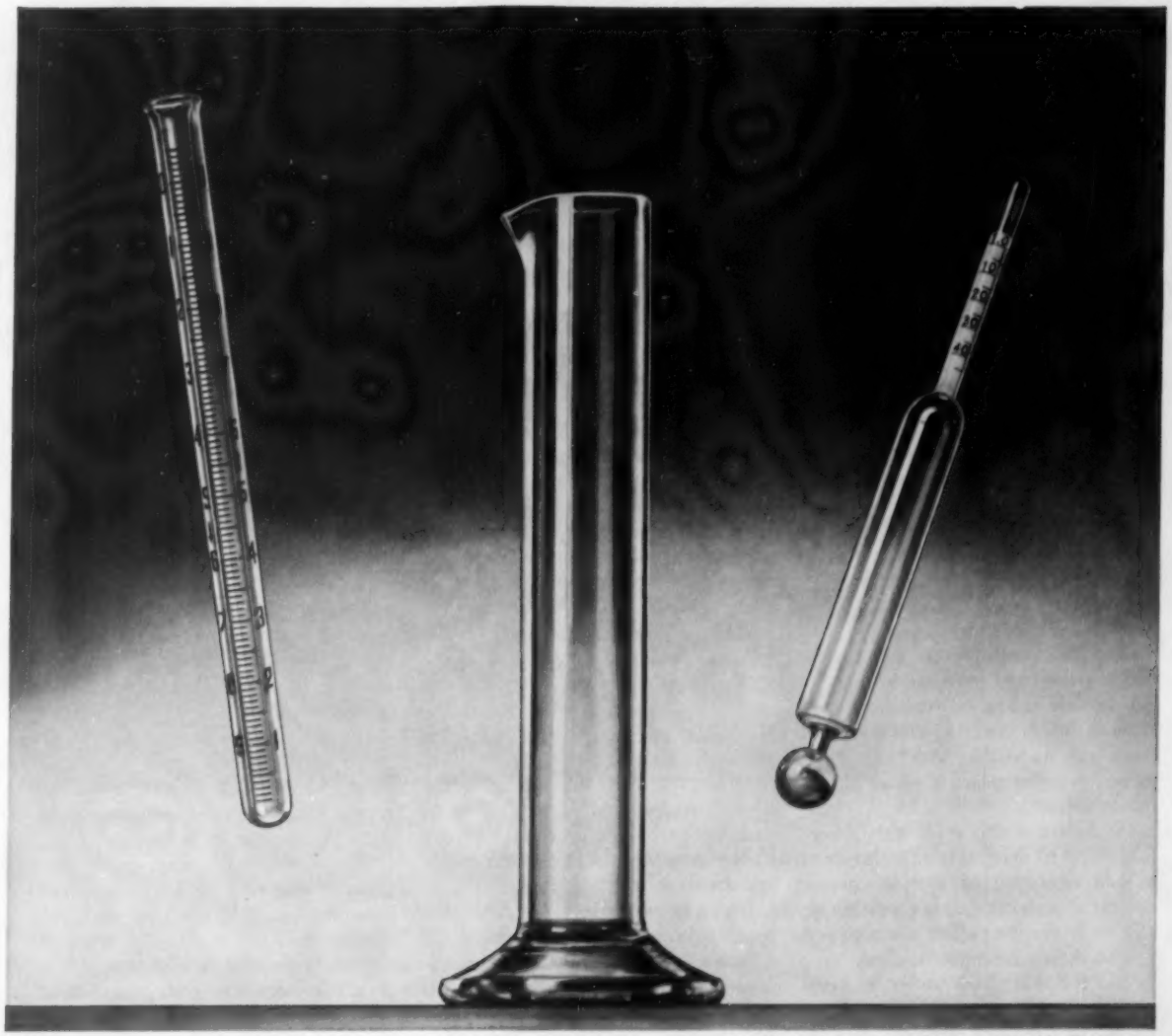
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(*Continued From Page* 100)

I am sure that most administrators who do not promote, and do not expect to promote, the preparation of solutions in their institutions still fear the results of poor technics used in the past when patients frequently reacted pyrogenically from hospital-prepared solutions. Modern equipment and technics eliminate that hazard. Water stills deliver an excellent quality of distillate. The continued assurance of this quality is controlled by the use of conductivity meters of the recording type, the alarm type, or a combination of both. For modern technics, there is equipment designed to clean flasks, closures, needles and syringes properly. Disposable administration sets are also available. These sets were the main sources of pyrogenic reactions not too many years ago. It is the general consensus that hospitals which make their own solutions must have a laboratory equipped with animals for making pyrogenic and bacteriological tests of solutions before they can be used. This definitely is not true. If these prepared solutions involved interstate commerce, then bacteriological and animal tests would be necessary. When solutions are prepared in the especially designed sealed flasks available today and proper technics are adhered to, they remain pure and sterile indefinitely, and can be checked by the usual water hammer produced by a flask of solution that contains a vacuum. If this vacuum is undisturbed, it can be assumed that the flask is as sterile as it was the moment it was removed from the sterilizer. In 1936 I instituted the manufacture of intravenous solutions in the City Hospital of Akron, Ohio, where I was chief pharmacist and later assistant director. During this 18 year period, approximately one-third of a million flasks and vials of sterile solutions were prepared at that Akron institution.

At Huron Road Hospital, an institution of 335 beds, 40,000 units of parenteral solutions are prepared annually at an approximate savings of $20,000 per year. Hundreds of thousands of patients throughout the country have received intravenous injections with solutions prepared in more than 200 hospitals that make their own intravenous solutions. These hospitals are really succeeding in doing something about cutting costs. I feel that every hospital in the country should give this modern procedure serious consideration.



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Time Study on New Enema Technic

WILLIAM H. KEHLMANN
Geriatrics Associates, Inc.
Brooklyn, N.Y.

WITH operating costs continually rising, it is imperative for every hospital or nursing home administrator to be continually on the alert for new methods or improved equipment that might effect economies while at the same time maintaining standards.

An excellent case in point may be found in the administration of the routine enema. Few procedures in normal patient care are more time consuming. Yet when the usual equipment is used, it is virtually impossible to short-cut preparation, administration, clean-up and sterilization time.

I recently conducted time studies of a new enema technic employing a single-use disposable unit* as compared to the standard method of administration:

Objectives of this study were threefold: (1) to determine time involved in administration of routine enemas compared with disposable enema units; (2) to determine patient reaction, and (3) to determine nurse reaction.

The following equipment was employed for the administration of an enema by the usual method:

1. Tray
2. Standard
3. Irrigating can
4. Rubber tubing
5. Glass connecting tube
6. Clamp
7. Rectal tube
8. Lubricant
9. Thermometer

When an enema is given by means of the disposable unit, the only equipment necessary is the unit itself. The enema may be administered at room temperature. It is apparent that the time saved in assembling equipment alone is no small item, to say nothing of savings caused by the elimination of "clean-up" and sterilization.

This disposable unit is composed of a 4½ ounce polyethylene "squeeze bottle" (containing per 100 cc., 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate) and an attachable rectal tube in a sealed cellophane envelope. An especially designed rubber diaphragm seated in the base of the tube prevents leakage and provides a controlled rate of flow. The enema solution is expressed by a steady one-hand squeeze on the collapsible plastic container. The empty unit is then discarded.

The tests were conducted in two nursing homes. Forty patients in the geriatric category were selected as subjects. Most of them were ambulatory, although there were a few bedridden and chair cases in the group. Careful time records were kept covering the administration of 57 enemas to the 40 patients over a four weeks' period. Times were then averaged and results are shown in Table 1.

It can be seen from this table that there is a net saving of almost 28 minutes of nurse's time *per enema* in administering with the disposable unit as compared to the time required by standard procedure. Total time saved in administering the 57 enemas included in this four-week test amounted to approximately 26½ hours. It hardly seems necessary to point out that time thus saved can be applied to extra service to the patient at the bedside.

In computing actual monetary savings in administering the disposable unit as compared to usual enema procedure, the average hourly pay rate of registered nurses, licensed practical nurses, and nurse's aides was used as a base. Figures quoted in Table 2 are average for the New York City area, where the study was made. Obviously, pay rates will vary in different parts of the country.

The table shows the comparative time cost for administering a routine enema with the usual equipment and with the disposable unit.

The institutional price of the disposable unit employed in these tests is from 36 to 40½ cents per unit. Although it is not within the scope of this study to determine exact comparative costs of time and materials of these two methods of enema administration, it is apparent that the cost of the disposable unit, plus the time cost

Table 1—Time Study of Enemas Given to 40 Geriatric Patients

	Standard Soap Suds Enema	Disposable Unit
Preparation time (average)	7.2 minutes	20 seconds
Instillation time (average)*	8.7 minutes	20 seconds
Clean-up, sterilization (average)	12.4 minutes	0 seconds
	28.3 minutes	40 seconds

*Nurses administering these test enemas were instructed to proceed slowly because of the age of the subjects. Hence instillation time may be somewhat longer than for the average person.

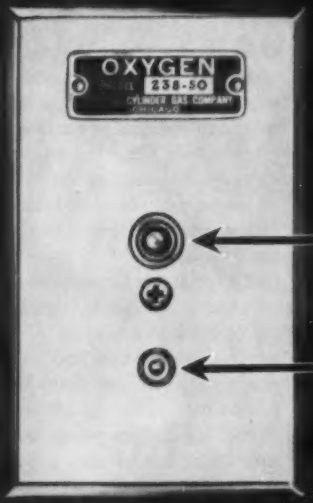
Table 2—Comparison of Time Costs in Administration of Enemas

		Time Cost of Administering	
Administered by	Average Hourly Pay Rate	Standard Soap Suds Enema	Disposable Unit
Registered nurse	$2.00	93.4c	2.2c
Licensed practical nurse	1.40	65.1	1.5
Nurse's aide or attendant	0.95	45.2	1.1

*Fleet Enema Disposable Units supplied through the courtesy of C. B. Fleet Co., Inc., Lynchburg, Va.

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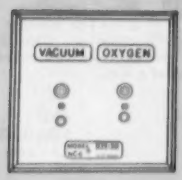


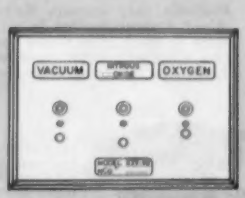
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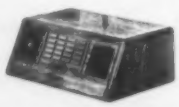
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of its administration, is far less than the prorated equipment cost of the standard enema plus the time cost of its administration.

Patient reaction to the administration of enemas with the disposable unit was excellent. There were virtually no complaints. This is indeed unusual considering that the test group was composed of geriatric cases and that elderly people are notoriously resistant to changes in routine or to anything new. On the whole, patients reported less discomfort with respect to pressure or pain from the disposable unit than when given the standard 1 quart enema.

According to Gross,[1] the rectum and sigmoid colon can be rapidly cleansed by rectal instillation of a solution of sodium biphosphate and sodium phosphate such as are contained in the disposable units employed in this study. He further points out that "the prompt action of such a solution is a decided advantage when rapid evacuation without spasm is desired." Gerwig[2] also states (in referring to this same unit) that "the results have been excellent in several hundred patients cleansed in this manner." And, according to Zollinger,[5] this method "makes cleansing of the lower bowel a quicker and more efficient procedure than the former method of castor oil and enemas."

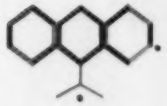
There is also ample clinical evidence that this solution is superior in cleansing effect to such commonly used enemas as tap water or saline solution in 1 to 2 pint quantities and less irritating than a similar volume of soap suds.[3, 4] Hence, even though the subjects described in this report were all in the geriatric category, we had no hesitancy in substituting the disposable enema units for the so-called "standard" enema. As previously stated, none of the subjects complained of any discomfort.

The reaction of our nursing staff was equally favorable. All personnel participating in this project was most appreciative of the material saving in preparation time, and the elimination of tedious and "messy" clean-up and sterilization.

References

[1] Gross, J. M.: J. Int. Coll. Surg., **23**:34, 1955.
[2] Gerwig, W. H.: GP **10**:35, 1954.
[3] Hamilton, H., in Trans. 5th Am. Cong. Obst. & Gyn., p. 69, Mosby, 1952.
[4] Swinton, N. W., personal communications with C. B. Fleet Co., Inc., 1954.
[5] Zollinger, R. M.: Kansas City Med. J., **30**:14, 1954.

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10 mg. tablets	Bottles of 50 Bottles of 500	2.13 each 20.24 each
25 mg. tablets	Bottles of 50 Bottles of 500	3.03 each 28.79 each
50 mg. tablets	Bottles of 50 Bottles of 500	4.23 each 40.20 each
100 mg. tablets	Bottles of 50 Bottles of 500	5.70 each 54.50 each

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Prepared by the Department of Pharmacology
Emory University, Georgia

Classification, characteristics and treatment of

Epileptic Seizures

THE following outline covers the classification, characteristics and treatment of epileptic seizures:

PETIT MAL

EEG—generalized 3/sec. spike and wave.

Tridione, paradione, amphetamine, diamox, milontin, mysoline, phenobarbital, dilantin.

Transient (5 to 30 sec.) loss of awareness. May simply stare, or may have batting of eyelids or rhythmic jerking of the extremities. Attack may be induced by hyperventilation 1-4 min.

MINOR MOTOR

EEG—petit mal variant pattern.

Dilantin, phenobarbital, mebaral, mesantoin, mysoline, diamox (pyridoxine?).

1. Akinetic or drop seizures.
   Abrupt loss of postural tone, patient suddenly falling to the ground. Consciousness may or may not be retained.
2. Myoclonic seizures.
   Irregularly distributed clonic movements of the trunk or upper extremities and rarely of the lower extremities. May occur at any time of day, but tend to be more frequent in the early hours of the day.

MAJOR MOTOR

EEG—variety of patterns (generalized).

Phenobarbital, mebaral, dilantin, mysoline, mesantoin, hibicon, bromides.

No aura, "simultaneous" loss of consciousness and generalized motor seizure—tonic, clonic, atonic, or tonic-clonic, often followed by period of confusion, drowsiness or sleep.

FOCAL (CORTICAL)

EEG—variety of localized abnormal waves or spikes.

Phenobarbital, dilantin, mebaral, mysoline, mesantoin, hibicon, phenurone, bromides.

A. Unconscious—frontal lobe.

B. Motor—posterior or intermediate frontal region.

1. Excitatory.
   (a) Jacksonian.
   Clonic or tonic movement of any part of body (usually hand, face or tongue, or foot). May remain localized or progress to a generalized seizure.
   (b) Adversive or head turning.
   Head and eyes turn to contralateral side. Patient may or may not have awareness of act.
2. Inhibitory.
   Sudden development of weakness or heaviness of an extremity or one side of body, or inability to speak.

C. Somatic—postcentral convolution (or precentral or posterior parietal area).
Sudden feeling of numbness, tingling, warmth or cold, kinesthetic sensation, or tickling in one part of body.

D. Visceral—Island of Reil, diencephalon, cingular gyrus, and so on.
Sudden occurrence of sinking feeling, epigastric rising sensation, cramp or flutter in "stomach," lump in throat, sometimes with nausea. Usually followed by generalized motor seizure.

E. Uncinate—in or near uncus.
Hallucination of smell or taste. May be followed by grand mal seizure or a period of confusion.

F. Visual—occipital lobe (near pole).
Scotoma, flashing of white or colored lights in part of visual field, discrete visual patterns.

G. Vertiginous—posterior superior portion of temporal lobe.
Sensation of rotation or loss of equilibrium, sometimes accompanied by buzzing in opposite ear.

H. Auditory—first (superior) temporal gyrus.
Roaring, hissing or buzzing.

PSYCHOMOTOR

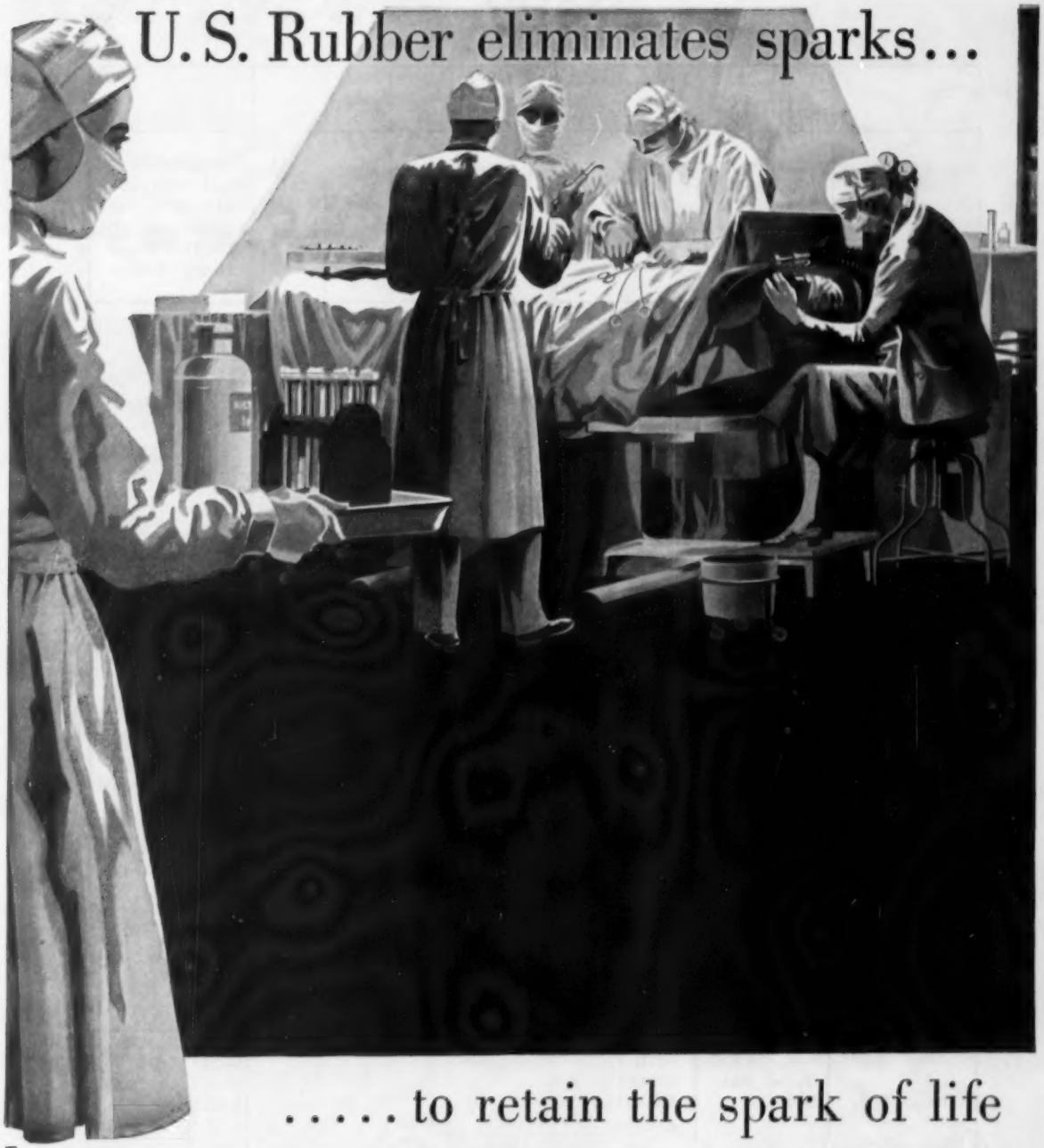
EEG—diphasic or positive spikes in anterior temporal region (sleep EEG record essential).

Focus in apex of temporal lobe, hippocampus, amygdala (subcortical).

Dilantin, phenobarbital, mebaral, mysoline, mesantoin, amphetamine, hibicon, tridione, phenurone.

Hallucination, dreamy state, perceptual illusion, fear, forced thinking, aphasia, déjà vu. Confusion with poorly coordinated but more or less purposeful movements of automatic character. Grand mal seizures commonly present also. About 50 per cent of these patients have personality disturbances and psychiatric disorder. Very

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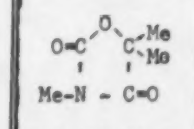
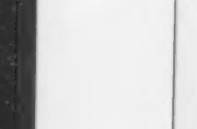
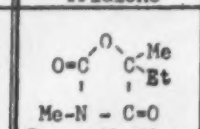
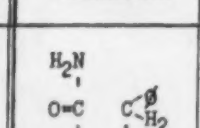
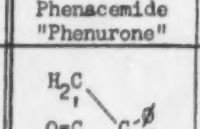
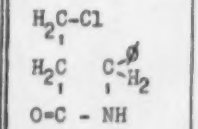
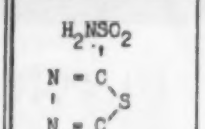
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ANTICONVULSANT DRUGS

Drug	Daily Dose (Gm.)	Use	Side Effects	Drug	Daily Dose (Gm.)	Use	Side Effects
NaBr or KBr Bromides	1.5	Grand mal	"Bromism" drowsiness skin rash	 Trimethadione "Tridione"	1-2	Petit mal	Photophobia, mild sedation, skin rash, nausea, agranulocytosis, kidney damage
 Phenobarbital	0.1-0.3	Grand mal & Petit mal	Drowsiness somnolence ataxia rare skin rashes	 Paramethadione "Paradione"	1-2	Petit mal	Same as above except lower incidence rash and photophobia
 Mephobarbital "Mebaral"	0.2-0.4	Grand mal & Petit mal	Drowsiness	 Phenacemide "Phenurone"	1-2	Grand mal & Petit mal	Anorexia, headache, insomnia muscular weakness, exaggerates personality defects, liver damage
 Primidone "Mysoline"	0.25 2.0	Grand mal & Petit mal	Drowsiness somnolence & Ataxia	 Milontin	1.5	Petit mal	Hematuria, drowsiness, nausea and dizziness
 Diphenylhydantoin "Dilantin"	0.2-0.6	Grand mal	Ataxia, hyperplasia of gums, nausea, diarrhea, insomnia, skin rash, constipation	 N-benzyl chloropropionamide "Hibicon"	1.5-3.0	Grand mal	Nausea and vomiting
 Mesantoin	0.2-0.6	Grand mal	Skin rash, drowsiness, aplastic anemia	 "Diamox" Acetazoleamide	0.25-1.0	Petit mal	Drowsiness and disorientation

difficult to control medically but more amenable to surgical treatment than any other type of epilepsy.

DIENCEPHALIC

EEG—14 and 6/sec. positive spikes (sleep EEG record essential).

Focus in thalamus, hypothalamus.

Dilantin, phenobarbital, mebaral, mysoline, mesantoin, estrogens (pyridoxine?).

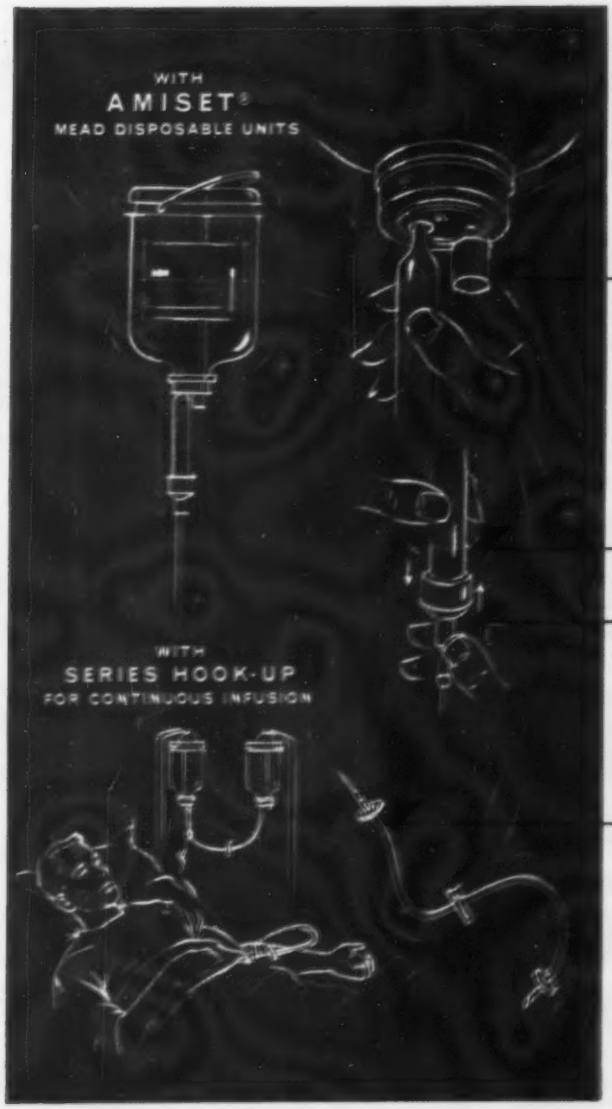
Abrupt occurrence of violent impulses and variety of affective reactions: pain, rage, emotional instability, attacks of dizziness, and autonomic disturbances. Convulsions occur in about 50 per cent of these patients.

(*Continued on Page* 112)

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(*Continued From Page* 110)

GENERAL PRINCIPLES OF DRUG THERAPY

1. Begin treatment with the safest drug likely to be helpful.
2. Administer the drug daily in divided doses (two to four).
3. Increase dosage progressively until seizures are controlled or maximum tolerated dose is reached or evidence of side actions becomes serious.
4. If improvement is not obtained with maximum tolerated dosage, withdraw this agent gradually, and substitute by 3 to 4 day overlap the next safest drug likely to be helpful.
5. If maximum tolerated dose reduces the frequency or severity of seizures without full control, continue with this drug and add the next safest drug likely to be helpful. Increase dose of second agent as in 3.
6. Effective combinations of 3 or even 4 drugs may be worked out by trial and error methods, following principles 4 and 5.
7. Medication should be administered for a number of years, and sometimes for life.
8. After a seizure-free period of two or more years, a very gradual withdrawal of medication may be tried —dose should be decreased monthly.
9. Special precautions are needed when using potentially toxic drugs (tridione, paradione, mesantoin, phenurone).
   A. Posssible untoward reactions should be explained to the patient or his family.
   B. Appropriate laboratory studies should be made before starting a toxic drug, and at monthly intervals thereafter (complete blood count, urinalysis, liver function tests).
   C. Periodic physical examination should be made to detect early signs of toxicity. Abnormal bleeding and trivial infection should be related to the physician by telephone.
   D. Discontinue offending drug promptly if signs or symptoms of bone marrow depression, abnormal bleeding, or exfoliative dermatitis occur.

GROUPING OF DRUGS ACCORDING TO RELATIVE SAFETY

SAFE

Phenobarbital, Mebaral } —Depression
Dilantin—insomnia, overgrowth of gums, hirsutism
Amphetamines—insomnia

APPARENTLY SAFE

Hibicon
Diamox—bone marrow depression
Mysoline—depression
Milontin—hematuria

TOXIC

Tridione—agranulocytosis
Mesantoin—agranulocytosis, skin rashes
Phenurone—liver impairment
Paradione—agranulocytosis

—JOHN DER. SLADE, M.D.,
HARRY L. WILLIAMS, M.D., CARL C. PFEIFFER, M.D.

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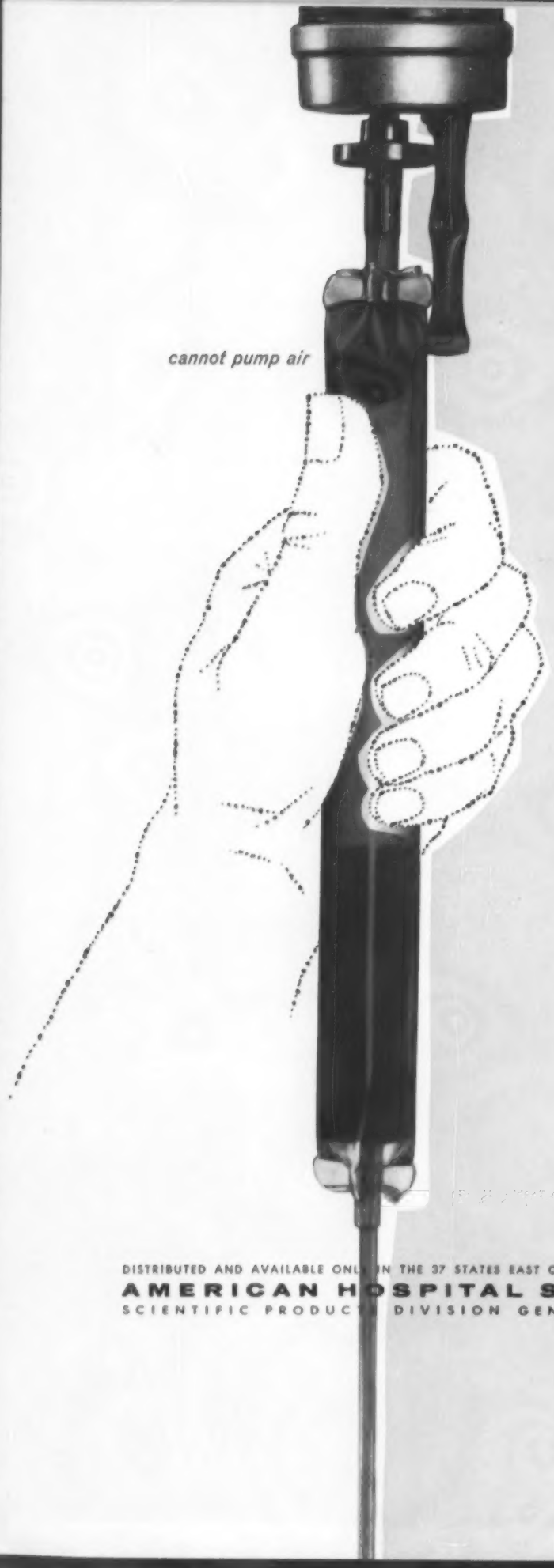
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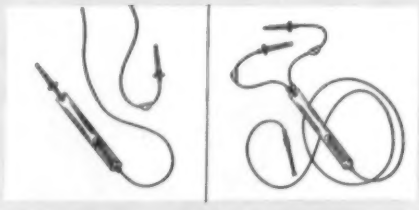
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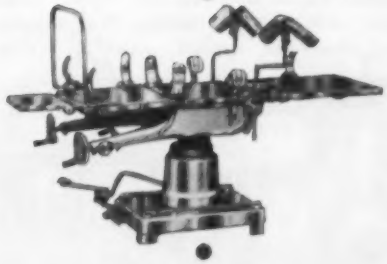
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FOOD AND FOOD SERVICE

Conducted by Mary P. Huddleson

The Cafeteria Comes to the Patients

1—Mobilteria Makes the Best of Two Systems

MARK STANTON
Administrator, McLeod Infirmary, Florence, S.C.

BRIEFLY and accurately stated, our patient feeding problem was that hot food arrived cold, and cold food melted—a familiar story. The approach to the problem was not to save $9500 per year in our dietary department, but that was the welcome by-product. Nor was it our intention to devise a *third* system in the discipline of feeding hospital patients—but what are we to call a method that is neither "centralized" nor "decentralized"?

We gravitated to the term Mobilteria system here at the McLeod Infirmary; the term is best defined as an incorporation of all the advantages of the "centralized" and "decentralized" dietary systems, with the disadvantages of neither.

The Mobilteria system is predicated upon assembly of the tray from a hot and cold food conveyor in front of the patient's door. The idea was conceived by W. G. Hunt, a steward in a 320 bed Virginia hospital, and developed by him in the 202 bed McLeod Infirmary, Florence, S.C. The growth of his idea, it is interesting to note, began in a hospital with a decentralized dietary service, and was completed in this hospital which has a centralized dietary service. Both hospitals were plagued by antiquated food delivery methods; but the Virginia hospital had the added problem, common to decentralized service, of 30-odd people doing serving from the 10 diet kitchens.

To effect a better method of food delivery, a hot and cold cart had to be built. Existing food conveyors did not present in one compact unit facilities for a *total* diet service. Each lacked something in the requirements to provide food service at the door of the patient's room.

The Mobilteria system almost died under the impact of all the requirements outlined for the development of that conveyor. Here are the original requisites:

1. It must carry food enough for 100 patients in a heated container and be capable of being refrigerated when needed for desserts and salads.
2. It must carry trays, dishes and so on for 100 patients.
3. It must provide separate space for from 14 to 18 per cent of meals as weighed or measured special diets.
4. It must have space for several liquids because of the liquid diet demand.

(*Continued on Page* 116)

Two views of the Mobilteria, showing (below) storage for cups and glasses, creamers, ice cream, butter and lemons; drawer for hot breads; special diet compartment; vacuum jugs for special liquids and tea and coffee, salad and dessert space; milk and ice storage; (below) space for dishes, trays, silverware, napkins, cups and coffee pots.





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5. Each hot food compartment must be individually controlled by thermostat.

6. It must be portable.

7. It should be of stainless metal for ease in cleaning.

With this set of postulates we thought our job was done; the rest of the work belonged to the engineers and fabricators. While we were congratulating each other, the big blow fell: The engineers said it might be easier to pipe the food to the patient's room or put the patient on a conveyor belt.

The second approach to the engineers was much less haphazard. The original seven stipulations still held, but Mr. Hunt had sketches of his dream gravy boat and plenty of detail in terms of volume of storage space and temperatures. A draftsman made scale drawings before the engineers took over. They made a paper model of the weights and measurements and came up with a device weighing something less than a Buick, but not much.

It was not until this point in the development of the Mobilteria that we realized that construction of a workable unit meant that Mr. Hunt had to bring to any meeting the engineers might have his own knowledge and skills in food management.

Even then the engineering of a device to do a total dietary job was not without problems, blunders of oversight. For instance, a frame was built and blueprints were made on one model, only to find it was too wide (2 inches) for a standard elevator door.

It is hard to be philosophical about labor pains, but it is supposed that no device is born without problems attendant.

The first food conveyor constructed we now lovingly call the "Essex"; it is antiquated now, but its delivery was important as a guide to the patients' reception of a new serving method. It was put into service as soon as the electrical circuits could be checked and the "newness" fried out of the heating elements. Half the hospital patients were fed and the time average was 45 seconds per patient. The "Essex" was in and out of service for two or more months. It would be used for a week, studied, and out of service for alterations. This was an important

TABLE 1—PERSONNEL COMPARISON

200 Bed Hospital—161 Patients—Dumb-Waiters to All Floors

Centralized Dietary System (Serving Time 1½ hours per meal)		Mobilteria System (Serving time 45 minutes per meal) utilizing two mobilteria conveyors
Food Assembly Supervisor	1	No kitchen assembly to supervise
Food Assembly Personnel. Assemble dishes on trays; serve trays from steam table; load dumb-waiters	5	No kitchen assembly to supervise
Dietary Clerks. To cover office from 6 a.m. until 7 p.m. for room check and diet changes	3	Changes are made on the spot. No unnecessary clerical help; no confusion concerning misinterpreted phone calls from nursing stations.
Serving Personnel. To serve patients from the dumb-waiters	3	Supervision and serving by two mobilteria units requires: Mobilteria supervisors 2; Mobilteria maids 2; Mobilteria butlers 2
Personnel Required	12	Personnel Required 6
*Maintenance and salary expense (weekly)	$372.00	*Maintenance and salary (weekly) $190.50

Mobilteria serves this hospital with ½ the personnel previously required, in ½ the time previously used!

*Meals for employes at cost of $0.50 per meal included

The chef loads the mobile cafeteria unit directly from the range. Refrigerated foods have already been loaded.



The Mobilteria butler unloads a standard elevator (1800 pound platform lift). Ice bin is shown next to the milk.



For every age—every day...

THE "CITRUS SNACK"



CHILDHOOD—to help correct and prevent vitamin C deficiencies reported in an alarmingly high percentage of grade school youngsters.



ADOLESCENCE—to give C-minus teen-agers the right kind of between-meals pick-up to effect C-plus nutrition.

MOTHERHOOD



—to help guard against anemia, hemorrhage and miscarriage in pregnancy, and meet the doubled C requirement during lactation.



OBESITY—to combat hypoglycemia, help control appetite and provide high-level C intake.



IN OLD AGE—to provide maximal C nutrition during this important period.

FLORIDA CITRUS COMMISSION
Lakeland, Florida

FLORIDA *Citrus*

ORANGES • GRAPEFRUIT • TANGERINES

TABLE 2—TIME STUDY ON LABOR SAVING

	Centralized System	Mobilteria System
Dumb-Waiter to All Floors		
Patients	161	161
Personnel	12	6
Serving time (minutes)	90	45
Total personnel serving minutes per meal	1080	270
Employes minutes/meal per patient	6.71	1.68

period in the system's development; we not only worked out the bugs in the machinery but developed method as well.

The patients began to complain when food was not served "the new way" anytime the "Essex" was in the shop. The patient reaction had some board members pushing for completion of our studies. To our knowledge this was the only place where patient complaints were received with a satisfied complacency by board members.

The second Mobilteria resembled the "Essex" no more than Bugs Bunny resembles the Paramount lion. It arrived one Friday. That Sunday night we ripped out the steam tables where we once assembled trays for dumbwaiter delivery to the floors. Monday morning our patient complaints on hot or cold food were ended; the Mobilteria system was installed.

The results of Mobilteria installation are as startling as was the concept of

(*Continued on Page* 120)

TABLE 3—SERVING CAPACITY

Hot Solid Foods

Three units with temperature ranges from 150°F. to 190°F. Each unit fits size No. 200 steam table pan of 32 quarts, and each individually controlled by thermostat. Fractional pans, to ⅛th of size may be used. Total capacity, 96 quarts. Hot bread drawer for 130°F.-150°F. All units are electrically heated and will retain heat for one hour or longer without appreciable drop in temperature. Preheat period is 40 minutes.

Special diet compartment for 14 weighed diets has temperature range of 150°F. to 180°F.

Cold Solid Foods

Space provided for:
- 100 butter pats
- 100 creamers
- 96 salads in 5¼ inch plates
- 108 desserts in 5 inch plates
- 35 lb. crushed ice

All cold foods refrigerated with dry ice.

Liquids

Coffee—5 gal.
Tea (cold or hot)—5 gal.
4 containers of 2 gal. each for other liquids such as clear broths, malted milks.
All liquids, hot or cold, are in vacuum containers.

China, Glassware, Implements and Condiments

Enough for 100 patients.

TABLE 4—WEIGHT AND DIMENSIONS

Height—75 15/16 inches
Length—77¼ inches
Width—33 inches
Loaded weight—1800 lbs. approx. (includes food and dishes)
Empty weight—1210 lbs.

TABLE 5—STORAGE TEMPERATURES FOR HOT FOODS IN THE MOBILTERIA

Class of Food	Desirable Temp. (°F.)
Vegetables	
Potatoes	
baked	185
boiled	175
fried	160
mashed	150
Green beans	155
Lima beans	155
Cabbage	155
Corn	155
Carrots	155
Peas	155
Rice	155
Tomatoes	155
Soups	175-190
Meats	
Roast beef	135
Roast lamb	150
Short ribs	160
Veal cutlets	160
Fried liver	160
Croquettes	160
Stews	160
Fish	140
Gravies	
Cream	140-150
Med. thick	155-165
Thin	175-185
Rolls	130

Temperature drop of food from time of loading Mobilteria to serving patient is approximately 5° F.

Student nurse oversees the preparation and distribution of special diets by the three-man team that handles the Mobilteria, *i.e.* a supervisor, a butler and a maid. The unit is easy to handle and can be maneuvered in 8 foot corridor.







first NEW paper cup in 25 Years!

Here's a great new companion to Sealright's famous plastic-coated Nestyle. Here's a completely new paper cup you asked us to create. Remember this. No other cup has these two exclusive features:

1. The **"bumper-roll edge"** gives a completely new feel for more pleasant, easier drinking.
2. Porcelainized completely. Sealright's new plastic-coating process now gives true-flavor protection for hot beverages. Plasti-cup is the first paper cup that makes you think you're drinking from a china cup.

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I'd like to try the new Plasti-Cup myself. Please send me two dozen.

Name..... Title.....

Company.....

Address.....

City..... Zone..... State.....

(*Continued From Page* 118)
tray assembly at the patient's door.

1. Assembly of trays, serving and clerical help, to accept change orders, required 12 people. We now use six and save $182 per week, $9464 per year.

2. Scrapped trays owing to delay in communications between the nursing service and the dietary department are eliminated. The centralized diet service is likely to waste food on discharged patients. This is a saving.

3. Once the system was in operation it became obvious that the nursing personnel was too divorced from patient eating habits or prescribed diets. Responsibility in that area has been fixed: The floor nurse accompanies the Mobilteria and is held responsible for special diets being delivered.

4. Selective menu is no longer selected by the patient the day prior to serving. The orders are taken by the Mobilteria supervisor 20 minutes before the Mobilteria goes to the floor.

5. In addition to reduction of personnel, the serving time has been reduced by half. This is a saving in man hours of 75 per cent. As crews have become more efficient in handling the Mobilteria, the time has been reduced to approximately 30 seconds per patient.

6. The system provides more than delivery of foods at the proper temperature. Freshly served foods are more attractive than those kept warm by other conveyor methods.

Recovery of dirty dishes requires some minor comment. The use of a second cart constructed for scrapping and assorting the dishes and trays is a post-meal operation. No study has been made on the time required, but dishes arrive sorted and the dishwashing time has been markedly decreased.

The tables on pages 116 and 118 tell more about the Mobilteria system than all the words in this article.

The Mobilteria saves time and money, and pays a bonus in public relations. It is not surprising that a hotel supply house has decided to have the device patented for its exclusive distribution. It will cost about $5400 per Mobilteria unit.

From our standpoint it is without parallel; it has, at last, eliminated complaints about hot or cold food. That the installation will amortize itself in a little over a year is, as previously stated, a welcome by-product.

2—Costs Go Down as Service Speeds Up

W. P. EARNGEY Jr.
Administrator, Harris Hospital, Fort Worth, Tex.

BELIEVING that cafeteria service is not only the most economical type of food service, but also provides the most palatable method of serving food in large quantities, the personnel of Harris Hospital, Fort Worth, Tex., headed by the steward and chief dietitian began, in 1951, to develop a piece of equipment which would employ the basic principles of this method of serving food, but which, at the same time, would be flexible enough to meet the strict dietary requirements of the medical staff.

After a comprehensive survey of the types of food service equipment available for patient service, the creative and cooperative phase began—cooperative because all departments of the hospital gave not only suggestions but also solace.

Harris Hospital, through the years, like many hospitals in the United States, had experimented with the completely centralized food system as well as the decentralized bulk food system.

The centralized system, while more economical from the standpoint of labor cost, had proved to be unsatisfactory in our situation because food could not be delivered to the patient in an edible and appetizing form.

The decentralized bulk food system posed fewer problems in patient food service. There were, however, definite conflicts between nursing care and food service at mealtime. In the decentralized system, the nurses were called upon to help deliver trays from the diet kitchen to the patient. Many times the nurses had to defer answering patients' requests for care or delay the food service.

This problem, coupled with the fact that there is inherent in the decentralized system a duplication of costly equipment and a need for a higher ratio of employes per patient, left much to be desired from both the service and the economic angle.

The equipment developed at Harris Hospital was specifically designed to handle enough hot and cold food, plus all dishes, condiments, silver and so on to serve approximately 70 patients, *i.e.* the capacity of our floors which are subdivided into two head nurse units. The service is mobile enough that the serving position can easily be changed four times during the distribution operation on any one floor.

(*Continued on Page* 122)

Fig. 1: The unit, which serves 70 patients, is wheeled into position to serve the first group of patients; then it moves on to the next stop.



Fig. 2: The pass-through window is open and serving begins. Two people working from opposite ends of the unit assemble trays for distribution.





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MORE THAN 16,000 patients a year are benefited by the most modern care and treatment facilities of the Cedars of Lebanon Hospital. In its free clinic, over 100,000 visits per year are made by patients who cannot afford private care. For its glassware service the hospital selected Libbey Heat-Treated Glasses. Are they satisfied? We think the letter shown above speaks for itself.

Libbey Heat-Treated Glasses are specially processed to stand up 3-5 times longer than ordinary tumblers under the heaviest service conditions. They take hard knocks and sterilization temperatures in stride. Through reduced breakage, you need fewer glassware replacements, smaller inventory, less storage space. And you get additional savings through Libbey's chip-resistant rims, guaranteed: "A new glass if the rim of a Libbey 'Safedge' glass ever chips."

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AN (O) PRODUCT

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GENERAL OFFICES · TOLEDO 1, OHIO



Fig. 3: The numbers on the cart show (1) deep wells and food pan inserts; (2) three shelves in the cooling unit; (3) storage racks; (4) collapsible shelves.



Fig. 4: Cold food section is coupled to refrigeration in the main kitchen.

The preparation of the food is centralized, and it arrives in bulk on the floor. While we capitalized on the economic advantages characteristic of centralized operation, we also retained the advantages of decentralized food distribution in that the serving does not take place until the cart has been strategically located on the floor (Fig. 1, p. 120).

The pass-through window is lowered and serving begins (Fig. 2). Two people, working from opposite ends of the unit, completely assemble the trays for distribution without interference from the personnel delivering the trays to the patient. After the first group of patients has been served, the unit is moved to the next position.

A similar unit is used for therapeutic diets. The therapeutic dietitian accompanies this unit and supervises the serving of the modified diets.

The unit is mounted on 8 inch casters which enable the employes who serve from it to handle its 700 pounds with ease. It is 70 inches long, 65½ inches high, and 20½ inches wide.

The height of the body of the unit is waist level; it contains the electrically heated food wells and pans, vertical tray conveyors (for dishwarming), and the refrigerated salad and dessert compartments. The three food pan openings will accommodate multiple combinations of food pan inserts.

In addition to the food pan inserts, there are three deep wells. The hot food area of the unit is insulated, and its heat is controlled by thermostats. After being disconnected from the power line, the unit retains its heat for about one and one-half hours (see Fig. 3, No. 1).

The cold food section is situated directly below the heated section. Direct coupling to refrigeration in the main kitchen chills the compartment (Fig. 4). The compartment holds a temperature of about 50°F. for two hours after being uncoupled. Other variations for cooling will allow the use of a special compressor unit, prefrozen plates, or the use of pans of crushed ice.

There are two food sections in the cooling unit, one on either side of the refrigeration unit. In each section the three shelves allow the variation of cooling needed for desserts and salads. These shelves measure 20 by 26 inches (Fig. 3, No. 2).

From approximately waist level up, the unit consists of racks and two shelves for storing wrapped silver, cups, glasses, packaged salt and pepper, sugar, packaged bread, crackers, trays and so on (see Fig. 3, No. 3).

While en route to the serving area, iced trays of beverages are placed on top of the serving surface of the unit. Upon arrival in the serving area, collapsible 15½ by 20½ inch shelves are raised at either end of the unit to provide more serving surface (see Fig. 3, No. 4).

Hot beverages, such as coffee, are served in individual vacuum containers, while hot toast is served directly from toasters mounted on the unit.

We have found the following advantages from the standpoints of both patient care and economics:

Patient Care:

1. Hot food gets to the patient hot.
2. Cold food gets there cold.
3. Patients who order from the selective menu can make last-minute changes in their orders.
4. Floor diet kitchen noises and odors are eliminated.

Economic:

1. Because of the positioning of the unit, less time of nursing personnel is required because fewer persons are needed to serve the trays.
2. Serving time. The general diet unit serves 70 patients in 30 minutes. The therapeutic unit serves as quickly, but the per patient time depends on the number of individuals to be served and the necessity of shifting the unit from floor to floor. (In small hospitals both the general and therapeutic diets could be served from the same unit.)
3. Personnel required:

Old System (decentralized)	
Supervisors	5
Assistant supervisors	5
Helpers	5
Relief	3
Vacation relief	1
Total	19

New System	
Cart Supervisors	1
Cart Waitresses	8
Relief	2
Vacation relief	1
Total	12

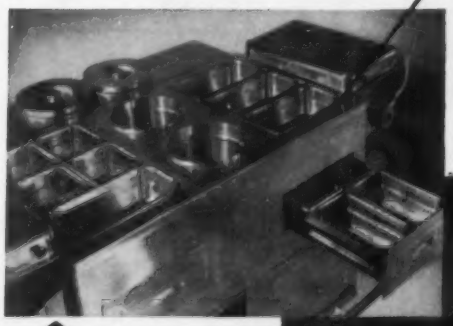
The payroll, on the basis of direct labor service to patients, has been reduced 30 per cent.

one food conveyor gives you dozens of inset arrangements for your selective menus

This new electrically-heated food conveyor is designed specifically for selective menus. It will contribute to successful diet-therapy in your hospital. Eighteen insets in various sizes can be placed in the wells in different combinations. These provide innumerable top deck arrangements to meet the requirements of any given meal. In addition to the two rectangular wells, there are two round wells for soup and broth and two heated drawers for special diets and rolls. The entire unit is made of heavy-gauge corrosion-resistant stainless steel. Top and body are of seamless, crevice-free construction, meeting the strictest hospital standards for sanitation and durability. If you're contemplating the "selective menu" idea, write for information about Model ALS-4922.



▲ EIGHTEEN square and rectangular stainless steel inserts in various sizes can be arranged in many combinations.



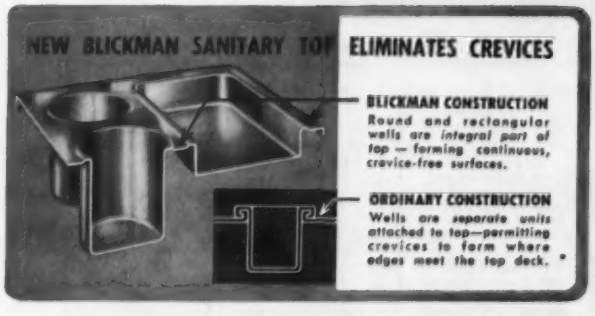
▲ *Above:* Today's menu may call for four square and four rectangular insets as shown here.

Right: While tomorrow, square and rectangular insets may be arranged like this. ▶





▲ *Above:* Still another arrangement is shown. Note the heated drawers and the convenient serving shelf.





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explaining merits of the "Selective Menu" and describing this and other Blickman Food Conveyors.

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You are welcome to our exhibit at the Catholic Hospital Association Convention, Kiel Auditorium, St. Louis, Mo., Booths No. 200-204, May 16-19, and to the Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City, N.J., Booths No. 314-316, May 25-27.

Menus for June 1955

Irene Carleton
Chief Dietitian
Middletown Hospital
Middletown, Ohio

1 Prunes, Orange Slice Soft Cooked Egg, Bacon • Stewed Chicken Dumplings Frozen Lima Beans Mixed Fruit Salad, Whipped Cream Dressing Ice Cream • Tomato Madrilène Beef and Noodles Spinach With Lemon Pickled Beet and Deviled Egg Salad Upside Down Cake With Whipped Cream	**2** Grapefruit Segments Poached Egg, Raisin Toast • Meat Loaf, Spiced Pear Garnish Creamed Potatoes and Green Beans Tossed Vegetable Salad Chocolate Layer Cake • Vegetable Soup Roast Pork Sandwich With Gravy Buttered Apples Lettuce Salad, Thousand Island Dressing Vanilla Pudding With Mandarin Orange Garnish	**3** Banana Scrambled Eggs, Roll • Tuna-Noodle Casserole, Potato Chip Topping Frozen Peas Hot Roll Mixed Fruit Salad Sherbet Assorted Cookies • Fried Fillet of Sole, Tartare Sauce Parslied Potatoes Harvard Beets Sliced Orange Salad Coconut Cream Pie	**4** Fresh Applesauce Fried Egg, Muffins • Beef Stew on Mashed Potatoes Parker House Roll Tomato Wedge, Cottage Cheese Salad Blueberry Cobbler • Braised Liver, Bacon Escalloped Potatoes Mixed Vegetables Apricot, Grape and Pear Salad Strawberry Bavarian With Whipped Cream	**5** Frozen Orange Juice Soft Cooked Egg, Doughnut • Roast Turkey, Gravy Sage Dressing Mashed Potatoes Buttered Broccoli Fruited Gelatin Salad Vanilla Ice Cream • Cream of Mushroom Soup Sliced Ham Potato Salad Hard Roll Assorted Relishes Fresh Fruit Cup Chocolate Chip Cookies	**6** Apricot Nectar Pancakes, Sausages • Vegetable Soup Beef Barbecue on Bun Macaroni and Cheese Tomato Stuffed With Coleslaw Cherry Tart With Whipped Cream • Swiss Steak Mashed Potatoes, Gravy Fresh Green Beans Pineapple Prune Salad Tapioca Cream
7 Frozen Orange Juice Soft Cooked Egg, Bacon • Italian Spaghetti, Meat Balls Fresh Fruit Salad Bread Sticks Banana Gelatin • Breaded Veal Cutlet Buttered Potatoes Creamed Peas Carrot-Raisin Salad Oatmeal Apple Krinkle	**8** Grape Nectar Fried Egg, Nut Roll • Corn Chowder Fruit Plate With Cottage Cheese Date Bread Sandwich Celery and Carrot Sticks White Cake, Chocolate Marshmallow Icing • Fried Chicken Mashed Potatoes Buttered Spinach, Lemon Tomato Salad Ice Cream	**9** Orange Slices Poached Egg, Bacon • Vegetable Soup Corned Beef and Cabbage Cornbread Peach With Cottage Cheese and Cranberries Pecan Pie • Baked Ham Glazed Sweet Potato Parslied Wax Beans Waldorf Salad Chocolate Pudding With Whipped Cream	**10** Tomato Juice French Toast, Sirup • Cream of Tomato Soup Tunaburger, Pickles French Fried Potatoes Coleslaw Fresh Strawberry Shortcake • Fried Perch, Tartare Sauce Creamed Potatoes Buttered Broccoli Mandarin Orange and Pineapple Salad Lemon Meringue Pie	**11** Grapefruit Segments Fried Egg, Cornbread • Roast Beef Vegetable Plate With Frozen Peas, Whole Carrots, and Sliced Beets Cloverleaf Roll Pear, Lime Gelatin Salad Butterscotch Pudding • Salisbury Steak Oven Browned Potatoes Cauliflower au Gratin Tossed Vegetable Salad Pineapple Fruit Cup	**12** Frozen Orange Juice Soft Cooked Egg, Bacon • Baked Half Chicken Sage Dressing Mashed Potatoes Green Beans Mixed Fresh Fruit Salad Chocolate Ice Cream • Cream of Potato Soup Ham Sandwich au Gratin Spiced Applesauce Deviled Egg Stuffed Celery, Olives Marble Cake
13 Stewed Apricots Soft Cooked Egg, Ham • Meat Pie With Biscuit Top Buttered Asparagus Jellied Salad of Fresh Strawberries With Cream Cheese Nut Ball Banana Cream Pie • Roast Beef Baked Stuffed Potato Frozen Peas and Carrots Lettuce With Thousand Island Dressing Royal Anne Cherries Oatmeal Cookies	**14** Pineapple Juice Fried Egg, Muffins • Chicken Noodle Soup Creamed Ham and Peas on Cornbread Blush Pear Salad Applesauce Cake With Orange Icing • Braised Liver, Bacon Hashed Brown Potatoes Creamed Onions Tossed Vegetable Salad Frozen Peaches With Whipped Cream and Toasted Coconut	**15** Grapefruit Segments Bacon, Glazed Doughnut • Hamburger on Bun, Pickles and Tomato Slice Potato Chips Carrot Sticks Stuffed Celery Spiced Crabapple Maple Nut Parfait Pie • Stewed Chicken Mashed Potatoes Buttered Broccoli Apricot, Green Grape, and Banana Salad Chocolate Sundae	**16** Boysenberry Nectar French Toast, Bacon • Chicken Chow Mein Rice and Noodles Pineapple and Stuffed Prune Salad Brownie à la Mode • Pork Chop Escalloped Potatoes Whole Kernel Corn Whole Wheat Roll Tomato Stuffed With Coleslaw Fruited Gelatin With Whipped Cream	**17** Orange Slices Soft Cooked Egg, Toast • Split Pea Soup Fruit Plate With Tuna Salad Sandwich Assorted Relish Plate Ice Cream • Fillet of Sole Baked in Milk Parslied Potatoes Buttered Green Beans Peach, Pear and Fresh Cherry Salad Lime Chiffon Pie	**18** Prunes, Orange Slice Scrambled Eggs • Vegetable Soup Sliced Ham Buttered Whole Carrots Buttered Spinach Bran Muffin Kidney Bean Salad Fresh Strawberries • Veal Cutlet Mashed Potatoes Stewed Tomatoes Fruit Salad With Whipped Cream Dressing Chocolate Ice Cream Roll
19 Frozen Orange Juice Fried Egg, Bacon • Roast Turkey, Gravy Sage Dressing Glazed Sweet Potatoes Broccoli Jellied Pineapple and Orange Salad Vanilla Ice Cream • Turkey Rice Soup Roast Beef Sandwich, Gravy Buttered Peas Cottage Cheese and Tomato Salad Green Gage Plums	**20** Blended Juice Bacon, Cinnamon Toast • Barbecued Short Ribs Fried Potatoes Buttered Cabbage Wedge Carrot-Raisin Salad Fresh Fruit Cup • Roast Sirloin Mashed Potatoes Mixed Vegetables Cucumber-Tomato Salad Banana Cake	**21** Fresh Applesauce French Toast, Sausages • Vegetable Soup Creamed Chicken and Peas on Toast Peach-Cottage Cheese Salad Lemon Cake Custard • Meat Loaf Baked Potato Green Beans Tossed Vegetable Salad Fresh Stewed Rhubarb	**22** Grape Nectar Fried Egg, Bacon • Fruit Plate With Cottage Cheese Ham Salad Sandwich Relishes Strawberry Cream Pie • Swiss Steak Mashed Potatoes, Gravy Peas and Carrots Pear and Cheese Nut Ball Salad Chocolate Pudding With Coconut Garnish	**23** Tomato Juice Poached Egg, Bacon • Beef Stew on Mashed Potatoes Whole Wheat Roll Orange and Grapefruit Salad Cheese Cake • Fried Chicken French Fried Potatoes Wilted Lettuce Apricot Salad White Cake With White Icing	**24** Orange Slices Scrambled Eggs, Toast • Salmon Croquettes With Pea Sauce Buttered Potatoes Buttered Beets Fresh Fruit Salad Cherry Cobbler • Fried Cod, Tartare Sauce Escalloped Potatoes Broccoli Tossed Vegetable Salad Lime Sherbet
25 Pineapple Juice Pancakes, Bacon • Chicken Noodle Soup Macaroni, Cheese and Ham Casserole Fresh Green Beans Bran Muffin Coleslaw Fudge Cake • Swedish Meat Balls Creamed Potatoes Frozen Peas and Carrots Pineapple Salad Custard	**26** Frozen Orange Juice Soft Cooked Egg, Doughnut • Broiled Steak Mashed Potatoes Brussels Sprouts Jellied Orange, Pineapple, Green Grape Salad Ice Cream • Cream of Celery Soup Escalloped Turkey, Peas and Noodles Hard Roll Mixed Fruit Salad Lazy Daisy Cake	**27** Grapefruit Poached Egg, Biscuits • Sliced Ham Hot Potato Salad Parker House Roll Tomato Salad Apple Pie à la Mode • Pork Chop Escalloped Potatoes Whole Kernel Corn Lettuce, French Dressing Cantaloupe Ring With Fresh Cherries	**28** Grape Nectar Scrambled Egg, Bacon • Creamed Giblets and Mushrooms on Baked Potato Buttered Fresh Asparagus Fruited Gelatin Salad Strawberry Sundae • Roast Beef Oven Browned Potatoes Stewed Tomatoes Orange Slice, Pear and Green Grape Salad Bread Pudding With Lemon Sauce	**29** Orange Juice Soft Cooked Egg, Toast • Stewed Chicken Dumplings Frozen Lima Beans Mixed Fruit Salad Tapioca Cream • Ham Loaf Creamed Potatoes Parslied Wax Beans Frozen Fruit Salad Chocolate Layer Cake, Coconut Icing	**30** Pineapple Juice Scrambled Eggs, Roll • Vegetable Soup Baked Ham Macaroni and Cheese Whole Wheat Roll Tomato Salad With French Dressing Old English Apple Pie • Roast Beef Oven Browned Potatoes Parslied Carrots Grapefruit, Strawberry, Cream Cheese Salad Baked Custard

Ready-to-eat or cooked cereals served on all breakfast menus.

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An extensive survey dealing with the use of paper cups and containers in hospitals disclosed some remarkable facts. For example, the years-old idea that paper service for patient feeding was too expensive was completely dispelled. In fact, several leading hospitals learned *it actually costs less to feed patients with all-paper service than with conventional ware.*

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Selecting and Buying Paint

WALLACE A. MOYLE
Supervisor, Plant and Maintenance, University of Connecticut, Storrs

THE first property looked for in a paint is its ability to cover the surface on which it is applied. This is called hiding power. It is the degree of opaqueness developed by the film. If light penetrates the paint, strikes the surface, and is reflected back to the eye of the observer, the film is called transparent. This takes place in films formed of the vehicle alone. Pigments added to the film impede the travel of light and bend some of the rays away from the line of sight. As more pigment is added, more light is shunted away at many different angles. Finally a point is reached at which virtually all light rays are bent away from the line of sight, none is reflected from the surface being covered, and the film is said to be entirely opaque.

Paint coverage appears to have two components. One is the physical covering of a surface by applying a blanket of prime pigments having varying degrees of opacity. The other is by refracting light from the surface in such a way as to divert it away from the observer's line of sight. Refraction can be obtained by use of the so-called extender pigments, which are cheap in comparison with prime pigments. This creates an apparent hiding in the finished product that will show up well on the refracting meter.

This apparent coverage changes as the paint washes. Extender pigments generally are bulkier, resulting in a more porous film; they measurably reduce the durability of the product. Washing will be more difficult because of greater instability of the film and therefore will be costlier. The resultant surface will be more porous and less attractive owing to the change in refraction. Obviously this "apparent" coverage is cheap when compared with the "physical" coverage relying on the presence of the better grade, more expensive pigments.

The various pigment particles do not affect light transmission in the same degree. The effectiveness of each can be measured by instruments and is expressed numerically by a figure called the index of refraction. Some typical examples are:

Material	*Index of Refraction*
Titanium dioxide	2.76
Zinc oxide	2.02
Titanium calcium pigment	1.91
Asbestine	1.55
Silica	1.55
Heat bodied linseed oil	1.50
China wood oil	1.52

Attention is invited to the figures for inert or extender pigments (asbestine and silica), which are about the same as for the vehicles. They contribute little to actual hiding since they bend the light rays only slightly more than the vehicle itself.

The index of refraction of a mixed paint is an involved figure to obtain and complicated to use in a practical manner. A simpler system of hiding units has been worked out for the various pigments. Known as the Hallet System, it is based on the hiding effect produced by one pound of basic carbonate white lead as 1.00 unit. The hiding value of commonly used pigments already has been shown.



Brush is used for interior trim.

Poor quality flat paints often have an actual observed hiding far in excess of the number of units in a good material because of the fact they develop additional dry hiding. This results from a lack of sufficient binder properly to wet all of the pigment particles. When dry, some of the unwetted particles stick up in the air and reflect light. This condition is associated with poor film density and poor hiding of the film while still wet.

The film the maintenance man wants in an interior paint is the one that gives the thinnest, densest, smoothest, most durable coverage. This kind of a film assures excellent wear, supports stains and dirt substantially on the surface, washes easily, and reduces to a minimum the amount of material dislodged by each washing. The resultant clean layer must have the same or substantially the same characteristics as the top surface and each succeeding layer must likewise be satisfactory in coverage and appearance.

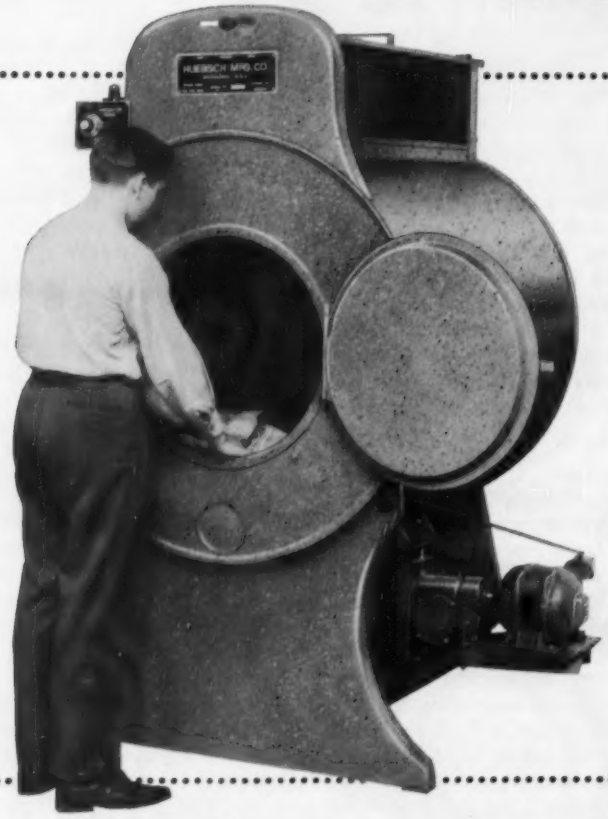
Reason says such a product must be carefully formulated of selected and more expensive components, controlled at every step of its manufacture, tested thoroughly, and that it must have reasonable margins of safety built in. Good grinding, for example, is necessary. The smaller the pigment particle and the finer the paint is ground, the greater the surface area per gram (or other unit) and the greater the tendency of the vehicle to wet it.

The comparison of the hiding units of the prime pigments is a solid basis for comparing dollar value, other characteristics being equal. Somewhere on the scale of hiding units there is a point at which one-coat hiding is reached and below which two coats are needed to assure complete cover-

This is the second and concluding section of the Connecticut study of the properties of paint. The first section appeared in the April issue of The MODERN HOSPITAL.

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age. There is substantial agreement that this point is 26 hiding units. A properly balanced 26 hiding unit paint probably will get a solid hide with one coat over any surface. If applied over a surface of approximately the same color, such a one-coat paint will produce complete hiding in all cases. If the 26 hiding units are calculated on the basis of the prime pigments, there is a safety factor to the extent of the value of the vehicle and any extender pigments.

Each hiding unit above 20 has a value of a little more than one up to some point between 30 and 35. In the latter range the law of diminishing returns begins to apply. Thus, if a 26 hiding unit paint will completely cover 500 square feet per gallon in one coat, one with 20 hiding units will cover only 20/26 as much with the same film. On the other hand, one with 30 units would be expected to cover 30/26 as much and result in a greater coverage per gallon. This can be translated into relative value.

The following calculations are based on the products of two highly reputable manufacturers. Both are alkyd resin flat paints. They have substantially the same characteristics both quantitative and qualitative. Paint A (26 H.U.) costs $3.15 per gallon. Paint B (22 H.U.) costs $2.90 per gallon. On the basis of hiding units the following equation will produce the relative value of Paint B to Paint A.

$$\text{Relative value Paint B} = \frac{\text{H.U. Paint B} \times \text{Cost Paint A}}{\text{H.U. Paint A}}$$

or

$$\frac{22 \times \$3.15}{26} = \$2.67 \text{ relative value Paint B to Paint A.}$$

What does this mean in terms of painting costs?

It has been demonstrated that one gallon of 26 H.U. paint will completely cover 500 square feet per gallon with one coat and that the 22 H.U. paint will cover proportionately less with the same amount of coverage. Then Paint B will cover approximately $22/26 \times 500 = 423$ square feet per gallon, or 77 square feet per gallon less (15.4 per cent less) than Paint A. Since Paint A covers 500 square feet, the cost of material is $\frac{\$3.15}{500}$, or $0.0063 per square foot. But to cover the same area with Paint B with the same amount of hiding will require 15.4 per cent more of Paint B or $2.95 + $0.45, or $3.40 compared with Paint A at $3.15.



Rolling paint on interior surfaces is faster and tends to eliminate variation in individual workman's technic.

On a comparable basis the material cost for 500 square feet using Paint B at $3.40 = $\frac{\$3.40}{500}$ = $0.0068 per square foot. This is an additional $0.0005 per square foot. This may not seem important until the item of labor is considered.

It is probably safe to say one painter using a 9 inch roller can apply one coat of paint to 1600 square feet per day on a flat surface with no preparation involved. Cost figures at the University of Connecticut, which include painting trim, show an average of 800 square feet per man per day. In terms of a 500 square foot per gallon paint this is $\frac{800}{500}$ or 1.6 gallons of paint per day. It makes little difference whether the paint is a 22 hiding unit paint or a 26 hiding unit paint; so far as the painter is concerned his daily average will be about the same in gallons. As a matter of fact, he may handle less of the 22 hiding unit paint because of the fussing necessary to get the necessary hiding. To get the same coverage with the 22 H.U. paint will require 115 per cent of 1.6 gallons or 1.85 gallons.

Labor is about 80 per cent of the cost of painting. The maximum annual pay rate at the University of Connecticut is $4200 per year. Since each employe is absent an average of 10 per cent of the time because of vacation, paid holidays, and sick leave, his productive work time is 2080 hrs. (40 hrs. × 52 weeks) −208 or 1872 hrs. The cost per hour worked then is $\frac{\$4200}{1872}$ or $2.13 per hour or $17.04 per eight-hour day. Translated into cost terms this is $17.04 for 800 square feet or $17.04 per 1.6 gallons of a 26 H.U. paint. The cost of labor then is $\frac{\$17.04}{800}$ or $0.0213 square feet or $\frac{\$17.04}{1.6}$ equals $10.65 per gallon. The initial cost per square foot of Paint A is $0.0213 (labor) + $0.0063 or $0.0276 per square foot.

The cost for Paint B is $0.0260 + $0.0068 or $0.0328 per square foot so Paint B costs $0.0052 per square foot more to use than does Paint A.

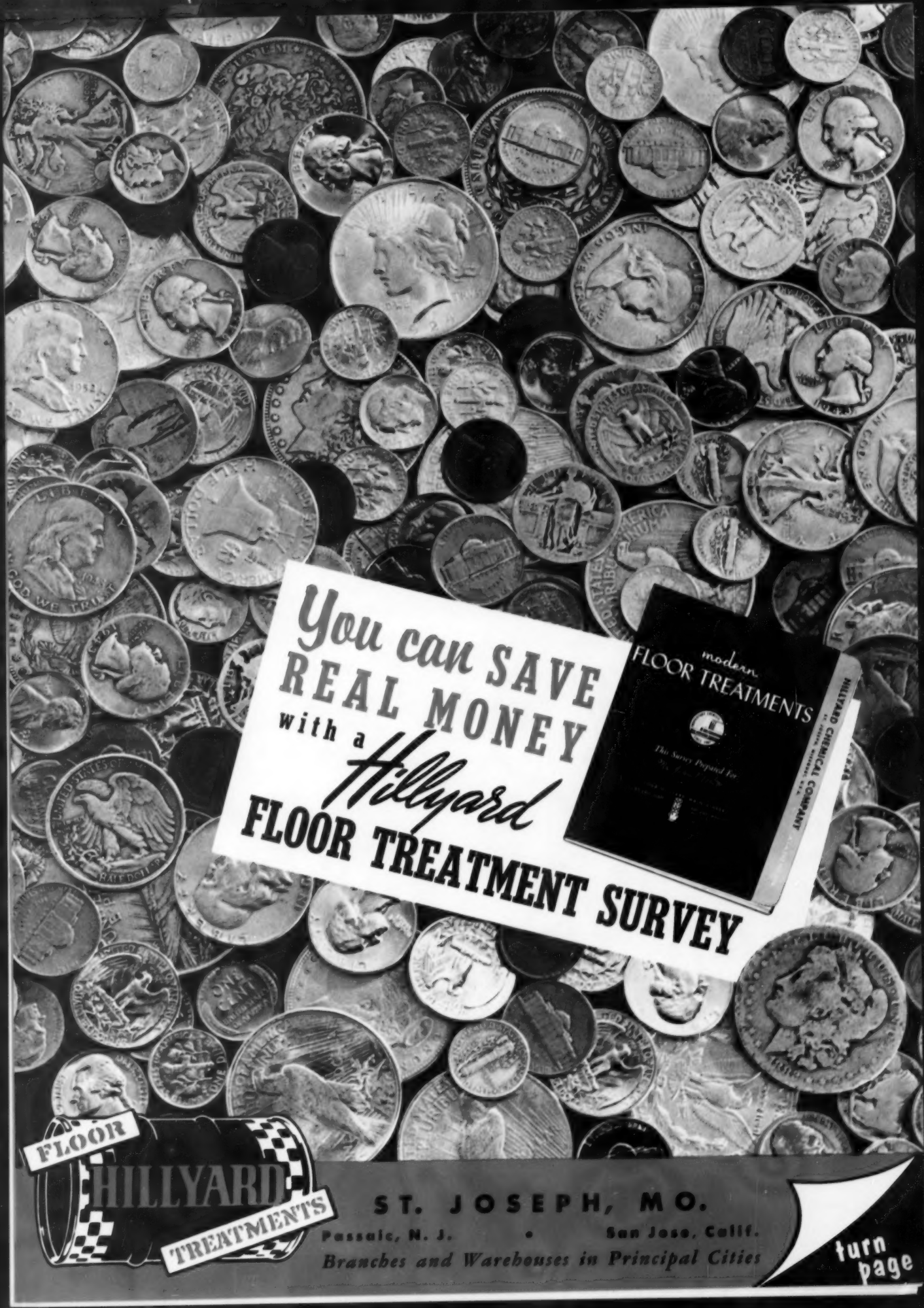
Let's look at another condition with regard to Paint B. Another vendor quoted us $3.14 per gallon. On the basis of 22/26 H.U. the calculated relative value of Paint B to Paint A is $2.67. At $3.14 per gallon this paint then is relatively overpriced $0.47 per gallon. At $3.14 + 15.4 per cent (amount needed to cover 500 square feet with same hiding as A) the comparative rated value is $3.62 or $\frac{\$3.62}{500}$ = $0.00724 per square foot. This is a difference of $0.0009 per square foot. On the basis of cost per square foot, Paint B at $3.14 per gallon is $0.0260 (labor) + $0.0072 (material) or $0.0332 per square foot.

To summarize the relative value on a hiding unit basis, see table below.

Let's translate this into annual figures for the painting operation at the University of Connecticut if only interior painting were done. There are 17 painters employed all year round. Each man is productive for 52 weeks, five days per week, eight hours per day, less vacations, sick leave, and holidays averaging 10 per cent or 260−26=234 working days. Figures used here do not include the item of preparation necessary before paint can be applied and the overhead. This averages one cent per square foot. The foregoing figures must be adjusted for this item and become $0.0313 for Paint A and $0.0376 for Paint B. Translated

Relative Value on a Hiding Unit Basis

Paint	H.U.	Rated Value	Relative Overprice	Add Req. for 500 sq. ft.	Cost per sq. ft.
A $3.15	26	$3.15	0	0	$0.0276
B 2.90	22	2.67	.23	15.4%	$0.0328
B 3.14	22	2.67	.47	15.4%	$0.0332


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into square footage per day for the two products, the results are 544 square feet per day for Paint A and 453 square feet per day for Paint B. Thus in 234 working days 17 painters will apply

Paint A—
234 × 544 × 17 = 2,164,032 sq. ft. per year
Paint B—
234 × 453 × 17 = 1,802,034 sq. ft. per year
361,998 sq. ft. less for Paint B.

This can be a measurable loss of 361,998 × $0.0313 or $11,330.53. The loss is $9,064.43 in labor against $2,266.10 for material. In other words, it would be necessary to add at least two more painters to get the same square foot production with the lower hiding unit paint.

NUMBER OF WASHINGS

Washing paint is a major part of paint maintenance. Students are paying customers and properly can expect the areas in which they live and work to be maintained in a reasonably good condition. This can be accomplished by washing. The custodial force must be employed on an annual basis in order to keep personnel, and this group is available for such jobs as washing paint as part of the annual detailed cleaning of buildings. This is not all the custodial force does during the summer. The conference schedule is substantial and service of the hotel type is provided, *i.e.* rooms are cleaned and beds made daily.

All dormitory areas are washed annually. Washability of paint is not just an academic matter nor is it one of merely removing a few spots and smudges. It is a complete washing of the entire wall surface.

One-coat hiding alkyd resin paints are now marketed by reputable manufacturers who will warrant that after each of eight to 10 washings the resultant effect, when dry, will be free of streaks and that repainting will not be necessary until that number of cleanings has been done. Since corridors, stairwells and recreation rooms receive more severe treatment they are washed about twice as often as are sleeping rooms, and eight to 10 washings are required of the product.

If a paint fails because it washes only four times before repainting is necessary the cost of using that paint to meet a "five washings" standard jumps 20 per cent. In addition, the entire painting schedule is upset and can be reestablished only by changing the standard, adding more manpower, or finding a material to meet the standard. Our experience assures us that suitable alkyd paints are regularly manufactured and marketed that meet the performance needed to maintain the present six-year standard.

The foregoing detailed discussion has dealt with material required to support only one standard. While it indicates the best materials cost but little more and their use may be justified administratively, some other material may fit another standard. If, for example, a two-coat system seems preferable a 20 hiding unit paint can safely be used if the additional labor cost is disregarded. It is doubtful whether a paint containing less than 20 hiding units is a "good buy" under any conditions. If there is to be no washing, one might also consider a paint with less exacting vehicle characteristics. A nonyellowing alkyd resin is not essential in deeper tints or colors and there are alkyds just as strong as the nonyellowing ones.

The following test of characteristics has been established for a semi-gloss alkyd white or tint.

Hiding units prime pigments	28
Vehicle nonvolatile by weight	49%
Pigment vehicle concentration by wght	47%
Grind	5
Stormer viscosity krab units	80 + 2
Overnight gloss 60° glossmeter	65-75%
Time to dry hard	12 hours

The differences are two more hiding units, 20½ per cent more nonvolatile vehicle, and 6 per cent more pigment vehicle concentration by weight. The grind is two numbers finer. It probably will wash 10 times without the necessity for repainting. The difference in characteristics indicates why it is a more expensive item. The same type of analysis can be made as described for the alkyd gloss.

The third type of paint for which the committee has established requirements is the one-coat exterior oil paint, white and tints.

The following description is intended to cover a first quality, balanced, self-cleaning, one-coat hiding oil paint for use on exterior surfaces. The paint shall be of first quality and a regularly manufactured and standard item of the producer, marketed for public purchase for *not less than five years* prior to the date of the bid.

The vehicle shall be a suitable blend of "bodied," "heat-treated," or "processed" pure linseed oil so treated as to provide controlled penetration of the surface to which this paint is applied, to which pure linseed oil has been added to impart suitable flow and leveling properties. "Pure linseed oil" as used in this description shall mean raw linseed oil from which fatty acids and similar detrimental ingredients have been substantially removed prior to other processing. The iodine number of the oil should be 183 to 188 to assure a high order of removal of fatty components, thereby assuring greater life through slower reaction.

The list of characteristics is:

Hiding units prime pigments	34
Film-forming solids by volume	85%
Stormer viscosity krab units	87 ± 2
Sq. ft. per gal. on smooth surface	550
Thickness of dry film	4 mils

The paint offered shall have been exposed on a substantial number of dwellings for at least four years, and the condition of this paint on the unshaded south side of such houses exposed open to the sun shall be good after four years.

The paint shall be capable of being applied with normal brushing technic at a film thickness of 4 mils when dry with little or no tendency to sag or to run when applied at that thickness. The film at that thickness shall dry normally and not be soft underneath as measured by a thumb smear test.

Other requirements are the same as previously listed except no washing test is applicable.

RESEARCH IS CONVINCING

At present the committee has no great amount of "personal" experience with this type of paint, but its research has convinced it the one-coat material is the answer to a lot of exterior paint problems.

First, a few words to the dyed-in-the-wool "oil and lead" painters. Up until the adoption of the alkyd resins for interior use, paints used at the University of Connecticut were lead and oil primarily because the two paint foremen, both master painters, had been brought up in that school. They have become converts to the use of new ready-mixed products. It was easier to sell them interior alkyds than it was exterior prepared materials. As studies proceeded it was found that the cost of mixing our own lead and oil paint was about 30 per cent higher than the highest priced, balanced, one-coat exterior paint. It was becoming increasingly difficult to find painters who could mix a consistently satisfactory product. A lot of time was wasted because only three or four of the crew knew how to match colors.

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Some other solution had to be found and it seemed to lie in the use of manufactured paints. Studies uncovered other reasons for some of our paint failures. Variation in oil was one. Variation in thinners was another.

The research, testing and advice of manufacturers' representatives in dealing with special problems was extremely valuable. As information from many sources was accumulated a list of characteristics emerged that defined the properties of a good material. Other considerations are the need for structural balance and the fact that, although the formula of the material is substantially the same, paints of different manufacture do not give the same performance.

GOOD APPEARANCE COMES FIRST

Exterior paints are designed to fail systematically in order to retain good appearance of the building on which they have been applied. A premium is placed upon their use. Good appearance at all times is traded for reduced durability.

Chalking in exterior paints is a feature of design. The linseed oil is broken down by the ultraviolet rays of the sun. This releases the hold of the binder on the pigments. In presence of moisture a zinc soap is formed that acts as a detergent, which helps the freed particles to wash off when the rains come, thus keeping the surface clean.

Probably the most important requirement is the sworn statement of the manufacturer that the paint has been used commercially on real houses and that after four years' exposure on the unshaded south side of real houses the paint is in good condition. National manufacturers who have led in the development of this item warrant their products will stand this test in Florida, Mississippi and other southern states. In northern areas this performance should be exceeded.

This combination of requirements is necessary. Unthickened oils are drawn out of the mixture by capillary action very easily. This results in spotty performance of the film, the strength of which is reduced by loss of the vehicle. In wood, oil may be drawn into cells many layers below the surface. This penetration can be limited by thickening the oil so it will not penetrate at all and then thinning it with pure linseed oil so it will anchor the film only in the top one or two layers of cells, which is sufficient. In this way the full film strength on the surface is retained.

The type and amount of prime pigments appear to be the key to good performance. Since titanium pigments are inert, they do not react as zinc and lead do. Thus they protect the oil from the rays of the sun to a greater degree and reduce the rate of failure. In a white or tinted exterior paint there must be a substantial proportion of such components to achieve the expected result. As colors are added, particularly the deeper ones, they perform this function and titanium pigments may be markedly reduced.

None of the committee has personal experience in the matter of relative costs for one-coat exterior paints. The reasoning found in the following example seems to be sound.

In exterior paints, the first cost in cents per square foot will be calculated on the basis of hiding units and square foot spread for each paint. This gives relative dollar values for the first cost. Then divide these figures by the number of years of life found by somebody's tests on real houses, to get the dollar value in terms of maintenance cost.

Consider a one-coat house at $7 in comparison to an orthodox one at $5 per gallon.

One coat applied at 350 sq. ft./gal.—film thickness 4.0 mils

Orthodox applied at 550 sq. ft./gal.—film thickness 2.15 mils

The one coat saves the labor of one coat of paint and, though its film thickness is not equal to two coats of orthodox paint, its greater hiding shields the oil better and gives it a life equal to the two coats of orthodox.

One coat

$$\frac{\text{Labor 2400 cents per day}}{\text{800 sq. ft.}} = 3¢ \text{ sq. ft.}$$

$$\frac{\text{Material 700 cents}}{\text{350 sq. ft.}} = 2¢ \text{ sq. ft.}$$

Capital outlay = 5.0¢ sq. ft.

Two coats orthodox

$$\text{1st coat labor } \frac{2400¢}{800} = 3¢ \text{ sq. ft.}$$

$$\text{2d coat labor } \frac{2400¢}{1000} = 2.4¢ \text{ sq. ft.}$$

$$\text{Material 1st coat } \frac{500¢}{550} = 0.9¢ \text{ sq. ft.}$$

$$\text{Material 2d coat } \frac{500¢}{600} = 0.83¢ \text{ sq. ft.}$$

Capital outlay.....7.13¢ per sq. ft.

Experience of this manufacturer shows a good one-coat paint erodes only 10 per cent of its film's thickness in four years in Florida, so its service life is hard to estimate. But one coat of it, because it is a thicker layer and the oil is more highly protected by its higher grade and greater pigmentation, *will last at least as long as* two coats of orthodox paint and probably longer. *Maintenance costs* then in cents per square foot per year are:

$$\text{One coat } \frac{5¢}{5 \text{ yr.}} = 1¢ \text{ per square foot per year.}$$

Two coats orthodox 7.13¢ = 1.42+¢ per sq. foot per year.

At the University of Connecticut, one-coat exterior paints were introduced last year. Preliminary studies indicate the calculations shown here are substantially correct and that exterior paint costs can be reduced drastically by use of a one-coat paint.

MATERIALS CAUSE FAILURES

The committee is convinced it has made out a strong case for purchase of products that will do a really dependable job, a job based on performance, a job that places the responsibility for performance of the products selected squarely where it belongs—on the shoulders of the manufacturer who made them. The committee's observation is that, when painting is done by skilled professionals, failures result most often from the material used rather than from failures of workmanship. For this reason new bid offerings will require that each can not only bear the manufacturer's label with the general analysis of the paint but also the manufacturer's instructions for thinning and other information as to use.

The purpose of this approach is obvious. It is to buy proven products from reputable manufacturers. There is no obligation in public purchasing to buy inferior products simply because someone offers them. The greater obligation is to the taxpayers, to carry on public business efficiently.

The committee does not presume to assert its method is foolproof or that other products of special manufacture may not be just as good. It does say the experience is lacking to prove this and that the state should not be the testing ground of unproven products at public expense when reputable manufacturers do that work as a part of routine operations. Our committee is convinced the method can be defended without apologies to anyone, that it provides a practical basis, that satisfactory products are assured, and that resultant costs will be favorable.

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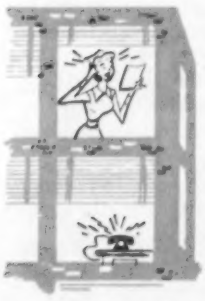
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Sprinklers Are a Liquid Asset

(*Continued From Page 87*)

Furthermore, N.F.P.A. records show that of 160 fires in hospitals and similar institutions in which automatic sprinklers were involved the systems extinguished 133 of these fires and held 24 of them in check. Sprinklers were 98.1 per cent satisfactory. Wherever automatic sprinkler systems have been installed in other than extremely hazardous occupancies where explosions might occur there never has been a loss of life. N.F.P.A. statistics further reveal that in hotels where standard systems of this type have been installed 70 per cent of fires were controlled by one sprinkler head, 100 per cent of fires were controlled by six heads or less.

The sprinkler type of protection in practically all cases sells itself.

In hospitals and similar institutions where these systems have been installed and maintained in satisfactory operating condition it is the opinion of management that by protecting the patients, staff and physical facilities with such a system the institution has provided the most positive method of preventing a disastrous fire that is available today.

Those of us in administrative positions are, or should be, conscious of fire hazard. We call to mind such glaring newspaper headlines as "74 Die in St. Anthony Hospital Fire," "Cedar Grove Nursing Home Fire Takes 18 Lives," "41 Lives Lost in Mercy Hospital Holocaust" to mention only a few. In addition to the lives lost there were untold losses in physical facilities in each case, as well as time lost in restoring these facilities, with resultant delay in caring for the sick.

We in Atlanta are fire conscious, especially since the catastrophic Winecoff Hotel fire in 1946 which claimed 119 lives. Since that time most of the major hospitals in Atlanta have installed sprinkler systems either throughout their facilities or at least in hazardous areas. Newer additions have been constructed of fire resistant materials.

Early in 1947 the Georgia Baptist Hospital, a general, nonprofit, short-term institution with present capacity of 471 beds and 72 bassinets installed two systems: one in what was then known as its surgical building (now the west wing of the main building); the other in its largest nurses' residence which at that time also accommodated a number of medical and obstetrical patients.

The west wing erected in 1926 is of reinforced concrete construction including concrete exterior walls, plastered tile block interior partitions, built-up tar and gravel roof, five stories in height with partial basement.

Because of the height of this building an underwriter approved fire pump was installed in the basement in connection with this sprinkler system. This pump automatically starts operating to supplement or boost city water pressure when the sprinkler system is activated. In addition to this system the hospital also installed a spiral type of fire escape which will accommodate a patient on a mattress. The type of construction materials renders this building virtually fireproof and fire rates on it have always been extremely low.

The largest nurses' residence in which the second system was installed was erected in 1920. It is a brick building with plastered, studded interior partitions, slate roof, three stories with full basement. Sprinklers were installed from attic to basement. A substantial reduction in fire insurance rates was realized here.

N.F.P.A. Records of Institutional Fires, 1935-1945

TYPE OF FIRE	PROPERTY NOT SPRINKLED		PROPERTY SPRINKLED	
	Number of Fires	Lives Lost	Number of Fires	Lives Lost
Hotels	545	1107	565	0
Schools	60	827	76	0
Hospitals	58	229	160	0

How Savings Vary With Construction, Use and Occupancy

BUILDING		COST OF SYSTEM	SAVINGS PER YEAR	YEARS TO PAY
1. Main building (west wing)	41,000 sq. ft.	$11,284	$ 119.19	95
2. Nurses' residence	48,300 sq. ft.	12,000	896.70	13.4
3. Warehouse, laundry and shop buildings	16,000 sq. ft.	4,508	1,381.80	
Boiler house	2,700 sq. ft.	.....	2,807.80	
			$4,189.60	1.1
4. Totals, three systems		$27,792	$5,205.49	5.34

REDUCTION IN RATES

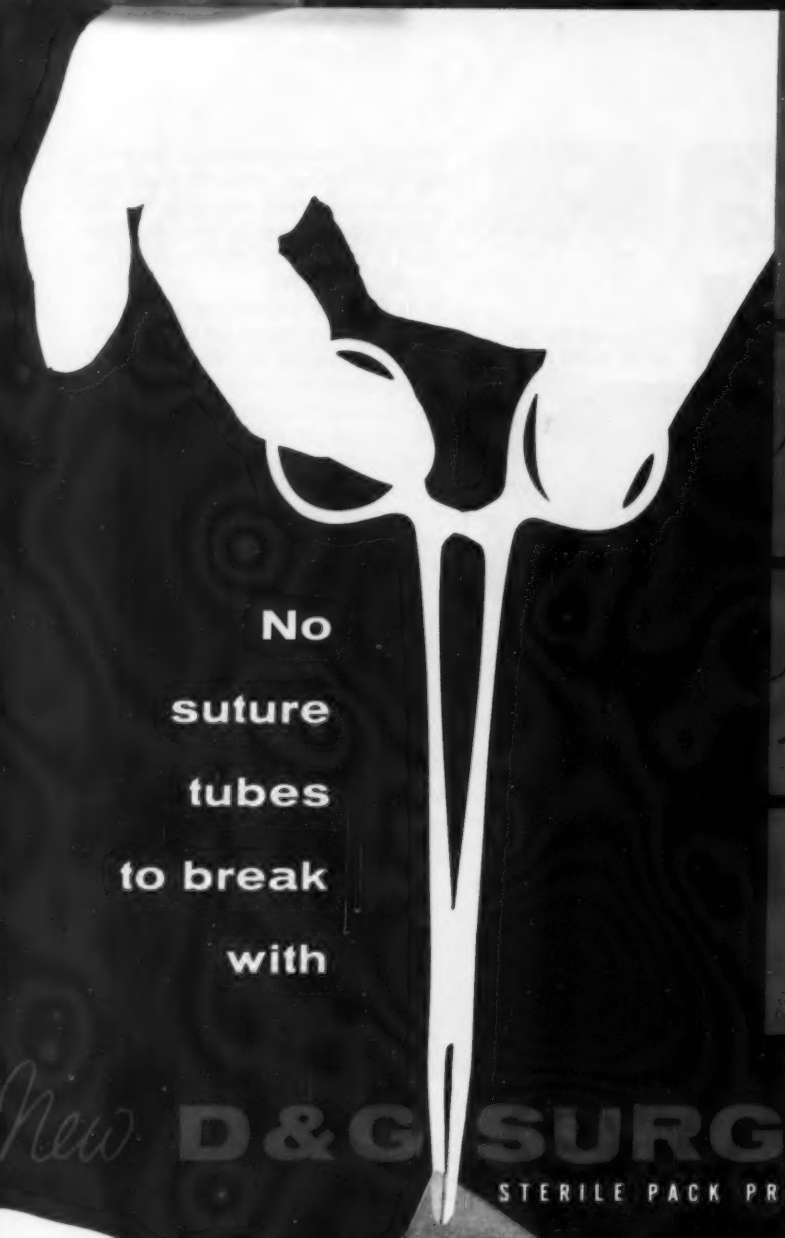
The warehouse, a reinforced concrete building with brick and tile exterior partitions and built-up tar and gravel roof, two stories, with 9500 square feet of floor area completed in 1952, is also equipped with a sprinkler system which has subsequently been extended to protect the adjacent laundry and shop buildings. These buildings are in turn adjacent to and integral with the boiler house. This group is separate and remote from the main building in which patients are housed. A substantial reduction in rates was realized when this system was installed since this group of buildings is considered very hazardous. Although this system does not extend into the boiler house itself, the rate on the boiler house was also substantially reduced owing to its proximity to a sprinkled building.

These three examples are offered as being representative of distinct situations and circumstances. A study of the accompanying tabulation will show that savings vary widely with type of construction and use and occupancy. Savings realized on all three systems substantially justified the installation of all of them.

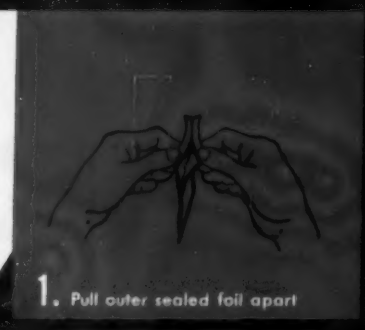
Example No. 1 indicates the desirability of fire-resistant construction.

Example No. 2 is a representative application where a fire in a building of this type of construction without such protection and with possible loss of lives would be most disastrous.

Example No. 3 is representative of the value of such protection in buildings where loss of materials would



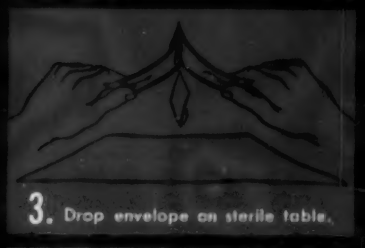
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2. Remove envelope with forceps or . . .



3. Drop envelope on sterile table.



4. Remove pre-cut sutures with tab.

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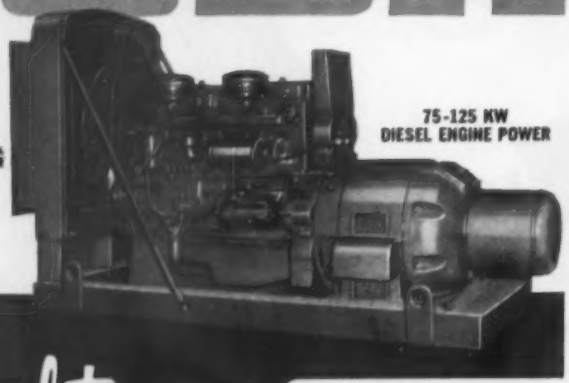
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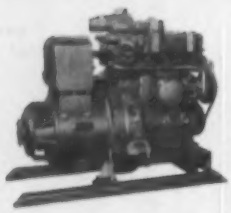
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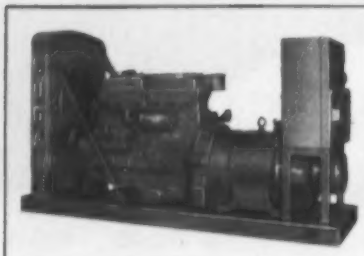
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definitely curtail operations. Disregarding the savings realized from the reduction in rates applying to the boiler house it can be seen that this third system would pay for itself in less than 3.3 years.

As has been pointed out, the chance of a fire growing to serious proportions is negligible where an automatic sprinkler system is provided. Therefore fire insurance premiums on buildings thus equipped are consequently reduced, often as much as from 40 to 90 per cent. It is not uncommon for a system to pay for itself in from five to eight years. After that it is money in your pocket.

Such systems can be installed by expert contractors in existing buildings without disrupting daily routine. Sprinkler contractors are most cooperative in scheduling their work to minimize any disturbances that are normally objectionable in a hospital. "Business as usual" was carried on during the installation of the system in our west wing. Pipes may be concealed but their appearance is not objectionable if the exposed arrangement is followed. Suppliers offer a variety of sprinkler heads including ornamental designs if desired.

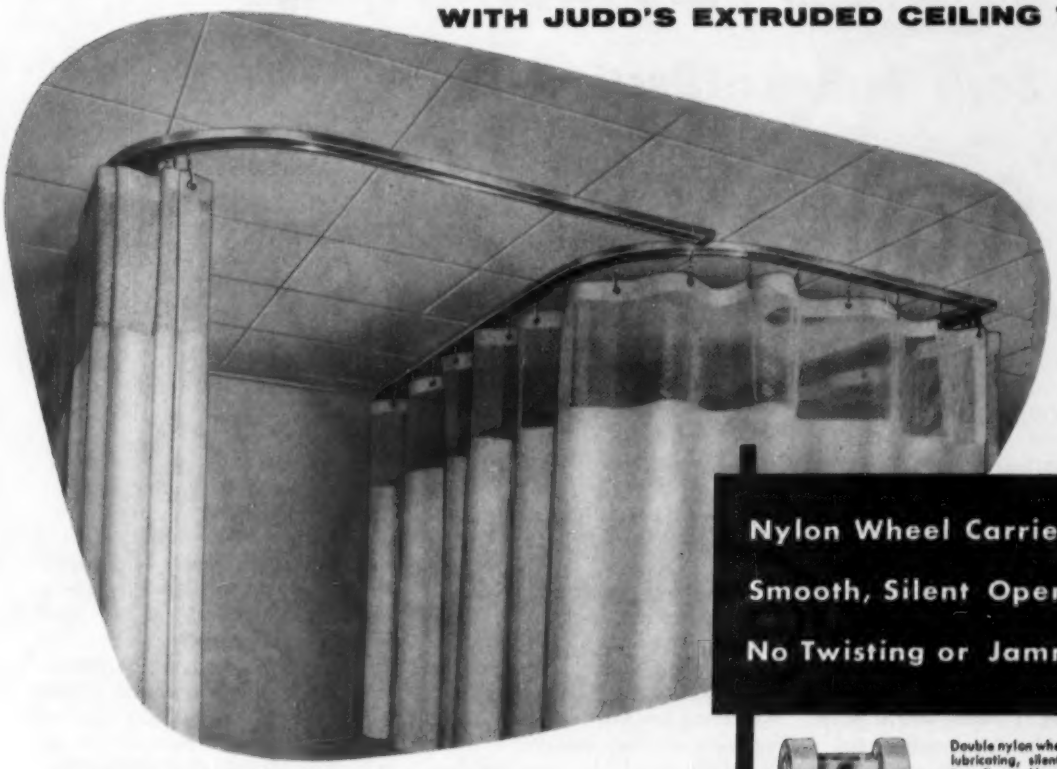
The advisability of maintaining the system properly cannot be overemphasized. Routine inspections usually once each year are made by insurance carriers and representatives of the National Board of Fire Underwriters. Periodic maintenance contracts with the sprinkler contractor are available at modest fees and ensure the system's being in satisfactory operation when needed. Hospital maintenance mechanics and night watchmen should be indoctrinated in the function of the system and should know what to do when it is activated.

Frequent inspections by the administrator or someone he may designate should be made to ascertain that supply valves have not been closed, that sprinkler heads have not been painted over, which would render them inoperative, that shelves and supplies or other possible obstructions are 12 to 18 inches below the level of the sprinkler heads.

Contemplated changes in interior partitioning should be referred to the underwriters for approval or study, since such alterations often will impair the efficiency of the system. An automatic sprinkler system is a cheap and vigilant watchman provided it is kept in readiness at all times.

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Lessons in Good Housekeeping

Basic Technics: Dusting—1

EMILY C. DEMING
Executive Housekeeper
Butterworth Hospital, Grand Rapids, Mich.

HERE beginneth the class on the most tiresome, unrewarding, repetitious, thoroughly disagreeable part of housekeeping, but since it's an extremely important part we're going to have to do it just as we do all of our other daily tasks. Can you guess what it is? No, we've covered mopping. What do you always do and do and do—and it never stays done? Yes, it's dusting!

Personally, I think that dusting is the most tedious and tiresome of all the jobs we do. It's the only one that I really dislike. I love to wax or polish furniture, and rub it until it has a beautiful shine to it, but just routine dusting I thoroughly dislike, and I'm sure that most of you do, because there's nothing I do more frequently than run my finger over an undusted surface. Dusting is terribly important and we must do it, and do it well, whether we like it or not. No matter what job we do there's always some part of it we don't like.

Did you ever stop to think what kinds of dusting there are? You watch what I'm doing with my hand and tell me what kind of dusting this would be. I'm moving it back and forth, am I not? All right, that's horizontal dusting. That's a nice word and I think we should all learn it. I'm going to put it on the blackboard. Learn it, learn how to spell it so that you won't forget it. We have horizontal dusting, and then what kind of dusting would this be?

Does anybody know the word meaning up and down? It's vertical—good! All right, we have both vertical and horizontal dusting, and practically all of the dusting we do falls into one of these two classifications. By and large, people do much better horizontal than vertical dusting. I've known people who always dusted the tops of the tables and never in the wide world dusted the legs.

Now, those two kinds of dusting divide themselves into three areas in which we find dusting to be done. I've got my hand way up here over my head. What would I be dusting? Not what thing but what area? I'd be doing high dusting, wouldn't I? And 'way down here I'd be doing low dusting. All right, what does that leave? It leaves the middle to be done. And again, generally speaking, we do so much better middle dusting than we do either high or low dusting. I can come into a room and find that usually you have done the areas that you can reach comfortably without either stretching or bending, but where do I often come up with dust on my fingers? That's just exactly right! All the places that take some effort or a little energy, and that you think if I'm in a hurry I'm not going to see, and that's not very often true, is it?

When we dust, what tools do we use? What methods do we use? Specifically, let's name the tools. You should answer in chorus the thing that I think you should use most frequently —a vacuum cleaner! The vacuum cleaner tools are meant to take the dust off many kinds of surfaces, and take it completely out of the room instead of just spreading it from one surface to another.

What is the next most effective method? A damp cloth, that's right. You may have a treated cloth, or treated paper. In some instances you may use a lightly oiled cloth, or a waxed cloth. You may use a dusting mitt. You may use dusting fingers. If I ever caught anybody using a feather duster there wouldn't be many feathers left anywhere very shortly because I think they were invented by the devil. They simply spread dust everywhere. But there are two things that most people forget, and they do a beautiful dusting job in certain inaccessible areas: They are a feather and a paint brush. Now where can you think of that a feather might be used? To get in very deep carving—yes, that's true. That's a good thought. To go through little tiny holes that you can't get anything else into? That's right. Another place in which they're very useful is in dusting and oiling the rods for traverse draperies. Just a tiny bit of oil brushed on a feather and run down the inner groove of the traverse rod track will make it slide easily and well.

The paint brush is used to brush a fine silk lamp shade, a carved teakwood lamp base, to clean the grooves of a carved figurine, to reach the tiny, remote spaces our fingers are too fat to go into. And always it is washed and dried carefully before it is put away for future use.

Hold up your hands, and let me see how many you have! Just one. I've got two! Yes, you've got two hands. How many hands do you use when you dust? No; how many do you *really* use? As a rule you use just one, don't you? When you see me demonstrating, how many hands do you see me using? Two, don't you? As long as the good Lord gave us two hands, let's learn to use two hands well and effectively. You

This is the seventh article in the series of "Lessons in Good Housekeeping" which began in the November 1954 issue of The MODERN HOSPITAL. The lecture on dusting will be continued in the June issue.



BULLETIN:
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know when you've learned to use two hands you can describe yourself with that perfectly beautiful word ambidextrous. It makes you sound so important and intelligent. So when we have learned to do vertical and horizontal dusting ambidextrously we have mastered a good housekeeping technic.

Now, we're going to look at the various things we have to dust, and you'll find that before we get through we're looking with a very jaundiced eye because I'm sure you have never realized how many parts there are to a window, how many kinds of lighting fixtures we have in the hospital, or how many places there are on the furniture that need to be dusted. So I want you to get one page in your notebook ready for each of these various items that we are going to analyze, and then find an illustration to paste in it that shows as well as possible the things we've discussed in class: the various parts of a window, the various kinds of lights, the parts of a radiator, how many areas there are on a door, and so on.

We are going to begin with windows, because windows admit more dirt than any other part of the hospital. What about a door? Yes, a door does admit lots of dirt, but except for exterior doors there isn't the same amount of blow-dirt and dust that there is from the window areas. And which do we have the most of? We have a great many more windows than we do doors, and therefore we have a great many more of these areas through which dirt can come. You know I always teach that if we keep the dirt out then we don't have to clean it up *in*—so the thing we must remember is that if we keep the window sills, outer and inner, the window ledges, and the screens clean we're going to have far less cleaning to do inside.

We're going to start here on the blackboard with a window. Let's draw a picture of one and then we will add all of the various things that may be used on windows. This is going to be the window to end all windows.

How many of you know how many windows there are in your assigned station? Well, when you go back up to work today you count them—and stop and think how much time it would take to do them if you *didn't* know how to do them well and quickly, and just think how much time it's going to take no matter how quickly and well you learn to do them! So this is an important section of our lesson.

What's the most obvious thing in the window, and the one that gives us away the fastest if we don't keep it clean? The glass, of course! All right, and the glass is hung in what we call sash. And then we have down here the window sills, the inner and the outer sill, and around the window we have the casing on the inside and then flat against the wall there is the frame. And after we have got this much drawn what do we have ump-teen of? Well, what's this up here at the center of the window—and down—it's a ledge, isn't it? And what do ledges do better than almost anything? They collect dust! And then we have any number of what?—Where am I running the chalk? That's right! Corners! If you're lucky and just have one pane of glass in each sash then you don't have as many, but suppose you have the big high windows in the old wings with 16 panes per sash? Don't, for goodness sakes, take time enough to count the corners—you'd never get them dusted!

A window has a lot of metal on it, and what general term will we use for that? We'll call it hardware. You look surprised when I say there's a lot of it. Let's list the hardware for a window.

HARDWARE ON WINDOWS

First of all there's what? Yes, the handgrips with which we raise and lower it and the lock with which we close it. All right, there are the pulleys, and there may be either a sash cord or a chain. On our heavy windows we use chains to raise or lower them. Yes, there are the glaziers' points that hold the putty in, good enough! There are all the fixtures that hold up the various window trimmings—shades, blinds, curtains, draperies—and that's all hardware. I expect a screen could be called hardware. And then you have the hinges and the hooks and the latches that hold them in place. So there's a lot of metal connected with the window, and that metal has to be kept clean and shining just as all the other metal in the house has to be.

Now, before we go on to finishing detail on these, let's list the rest of the things that may be part of the physical structure of a window. What do we sometimes have above a window? We sometimes have a transom, more frequently on an interior than an exterior window, but we have a transom, and that again generally has quite a bit of metal hardware operating it so that one can close and open it.

What do we find on the outside of windows? We mentioned one thing just a minute ago. That's right—screens! What else do we have? Storm windows—and that means more glass to be kept clean. During the winter they present a very definite problem in trying to keep two sets clean. We often find people don't understand how to raise or lower those that we have with exchangeable screens and storm windows, and there is a good deal of breakage in the storm windows. You must always report immediately—the minute you see it—any cracked or broken piece of window glass or a pulley or a chain or anything else in a window that is broken.

More frequently than not, the ventilator is located below the window; in some of the areas where the windows do not open or shut there is a ventilating device below it. It's a nasty thing to dust and clean and it generally blows the air where you don't want it anyway. But we still have to keep them clean. What else is used to control the air on a window? Yes, a deflector at the bottom of the window. That is a slanting piece of glass held in a frame of wood or metal which again has to be cleaned.

Let's move over to this section of the blackboard and draw all the things that we put on a window. You see, we build windows in a hospital or a home or any other area so that we may have light and air and God's great outdoors. And then what is the first thing we do? Generally we put a shade on it, don't we? And then over the shade we hang glass curtains, over the glass curtains we put heavy draperies—line them sometimes—and how much light and air do we get? Not very much, do we? And all of these things take hardware from this list over here to keep them in place.

What else do we use on our windows here very frequently? We have hundreds and hundreds of venetian blinds—horrible things to dust. Can you tell me one thing that's even harder to dust? That was a chorus from the private pavilion staff! You're so right—the interior shutters—but they're perfectly beautiful and they give us wonderful control of light and air and, except on a windy day when they rattle, the patients love them.

Now let's think of the tools we would use to clean a window. For the glass we'd have to have water, a basin, and a cloth. What would we put in the water—lots of soap suds? No? Good enough! If we did, what would

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happen? We'd have a horrid streaky window. What *do* we use? Well, depending on the window, we use a little bit of vinegar, a little bit of ammonia if it is very soiled, but if you're doing good work and keeping your windows up you need nothing but a damp cloth, and a soft cloth to dry and polish it—old diapers make the nicest polishing cloths. What does the window washer use? He uses a chamois to give it a little more polish than we do. Why don't I give you a chamois too? Well, we'd go broke buying them; even the window washer's chamois has a habit of disappearing periodically. No, we'll just stick to the good old discarded diaper technic, and still keep our windows just as nice and clean inside as can be.

The air deflectors have to be washed just as carefully as the windows. Then we do put soap in the water, and what do we wash? The window sills, inside and out. And how do we clean the stationary screens that can't be taken out anytime during the year? (And that breaks my heart, as you know.) The only tool that I have discovered that makes it possible for us to reach the top of them is a radiator brush. So, in addition to cleaning radiators, the long-handled, slender radiator brush will get up and brush the top part of the screen. And what do we use for the bottom? Our counter brush, because there's heavier soil there inasmuch as the window is opened more frequently at the bottom and there's more passage of air through it, and more dirt lodges in the meshes of the screens.

First you brush the screen, then brush the sill out thoroughly and then wash it, and it's an awfully good thing when you've finished washing the sill just to take your damp cloth and wipe the screen off with it. Your hair will simply curl at the amount of dirt you get off it, but if you take it off the screen, the next rain isn't quite as likely to spatter dirt on your window. And when someone is careless and lets the window stay open and there is a great deal of wind blowing, it doesn't soil and stain the draperies as sometimes happens when they have blown against a screen.

For this very top part of the window, what is the only thing you can use? Your vacuum cleaners, and of course, the first thing you do, always, is to remove all the dust you can. So, actually, you would begin with your vacuum cleaner, wouldn't you? You'd vacuum across the top, like this, and then turn the dusting tool and dust up underneath where there is a good deal of dressing hardware. Dust the top of the drapery or the top of the venetian blind—that's right. Then, if you are just doing a dusting job you adjust your venetian blind this way and dust in a straight even stroke across the blind. Then go up one tape and down the other. Now, reverse the blind and repeat the process. And remember we never, *never* raise or lower a venetian blind until we open the slats perfectly straight—like this. More than half our blind damage is caused by moving a closed blind.

Do any finishing that is necessary by hand, but the blinds shouldn't have to be hand dusted more than once a week if you do good, conscientious and frequent dusting with your vacuum cleaners.

What do we sometimes forget to dust? The cords! On the porches where the blinds are wide and the long cords come down on the floors and get soiled, then what do we do with the cords? We take a basin of water and some soap, and we scrub

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No mattress covers or rubber sheets to buy. SYKO miracle covering is waterproof and self-protecting. All seams sealed. Impervious to body fluids and wastes, disinfectants and deodorants. When soiled, just scrub with brush, soap and water.

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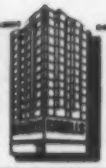
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*SYKO is a Trade Mark of THE REST-RITE BEDDING CO. Mattresses since 1898

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"Before purchasing any incubators, those in charge of premature care should carefully appraise all the available types . . ."[1]



Only the ISOLETTE provides all these lifesaving features:

Precisely regulated temperature, humidity and oxygen—"The Chapple incubator and isolation unit (The Isolette) provides temperature, humidity and oxygen control and filtered outside air within a chamber which is kept constantly closed."[2] "This incubator . . . has many advantages . . . visibility, the maintenance of a constant temperature and high humidity and the ease of caring for the baby without disturbing it or altering the environmental conditions greatly . . ."[3]

"excellent mechanical controls"[4]—"The incubator which we have found most efficient is the Isolette . . . the atmosphere within the unit can be kept at a constant temperature and humidity . . . it affords excellent visibility . . . (and) ease of handling the patient . . .

"By placing the baby in an Isolette . . . he can be protected from respiratory infections which might be lurking in the doctors and nurses who are in attendance."[5]

Useful as an isolation unit—"Individual air-conditioned incubators in which strict isolation is maintained at all times may be utilized for either the nonsuspect or the suspect infants . . . It may even be possible to omit an isolation nursery . . ."[6]

Protection from cross-infection by forced air circulation—"... individual isolation provided by Chapple's bed protected the baby from dangers of cross-infection . . . the infant is surrounded by conditioned fresh air drawn directly from outdoors and is further protected from all droplet infection . . . We now have four of the old-type Chapple beds and eight of the new-type 'Isolettes' and have at last achieved the ideal for which we aimed."[7]

High humidities without temperature variation—"In the forced air circulation type of incubator . . . it is possible to raise the humidity as high as 95% without varying the temperature within the incubator."[8]

Ice chamber for cooling—"... it is often overlooked that cooling may be equally as important (as warming) . . . Incubators with a forced air circulation system can lower the temperature effectively . . ."[8]

"Such incubators are expensive but certainly no more so than many another piece of hospital equipment that contributes to the saving of lives."[1]

the ISOLETTE the AIR-CONDITIONED Incubator

AIR-SHIELDS, INC. *Hatboro, Pa.*

1. Lull, C. B., and Kimbrough, R. A.: Clinical Obstetrics, Philadelphia, J. B. Lippincott Company, 1953, pp. 633, 634.
2. Hess, J. H., and Lundeen, Evelyn C.: The Premature Infant, ed. 2, Philadelphia, J. B. Lippincott Company, 1949, p. 43.
3. Davis, M. E., and Sheckler, Catherine E.: DeLee's Obstetrics for Nurses, ed. 15, Philadelphia, W. B. Saunders Company, 1951, p. 506.
4. Gross, R. E., and Ferguson, C. C.: Surgery in premature babies: observations from 159 cases, Surg., Gynec. & Obst. 95:631, 1952.
5. Gross, R. E.: The Surgery of Infancy and Childhood, Philadelphia, W. B. Saunders Company, 1953, p. 62.
6. Standards and Recommendations for Hospital Care of Newborn Infants, Evanston, Illinois, American Academy of Pediatrics, 1954, p. 58.
7. Clifford, S. H.: Infections of the newborn and premature infant, Penna. M. J. 53:25, 1950.
8. Dancis, J., and Cardullo, H. M.: Incubator care of the premature infant, Pediatrics 6:432, 1950.

There is no other incubator "just like the ISOLETTE" —regardless of price or superficial resemblance

the cords and dry them on a cloth so that they look fresh and clean. There's nothing that looks as tacky as an old dirty, stringy venetian blind cord. Now that we are restringing most of our blinds with plastic tape, the dirt wipes out of them much more readily than it does from the old cotton ones. I think cotton cords have certain advantages but it is not in the cleanability.

Curtains must be sent to the laundry according to a schedule, but in an individual room or area for some special reason they may become soiled and need to be taken down within the normal period, and then we have to have the houseman come in, and your supervisor will take care of that. You may find a single curtain that for some reason is dirty, perhaps something has been spilled on it. As you do your rooms each day you must note and report any such damage because if we can get to it quickly, many times we can get the stain out whereas if it stays and the sun shines on it, the curtain is ruined.

Interior shutters are dusted on exactly the same principle and by the same method that the venetian blinds are. You just have eight small sections to dust instead of the large sections of the venetian blind. You have umpteen hundreds of corners and ledges. You have to find time to hand-dust them frequently because soil clings to them much more readily than it does to the metal slats of the venetian blinds. Especially must you be careful to dust them where they open from the window and then fold back upon themselves. What sort of dusting would that be? No; horizontal would be what? That's right, going across the top of them. The back and the front and the dividing lines would be vertical dusting—see? But the most work is in all the horizontal dusting we have for all the little slats.

You also have to dust either the chain or the cord, whichever pulls the window up and down. I've seen many a window that's good and clean with a fuzzy-wuzzy chain, and it spoiled all the work that had been done on the rest of the window.

If a window gets stuck and it won't go up and it won't go down, before you go and call someone, take the chain like this, or the cord, whichever it happens to be, in your hand and gently and slowly pull it out in a little loop, and then lift—like this. Sometimes you can release the weight and then put it back very gently and very slowly. If you drop it, you can almost surely foul the thing up, but if you lower it very gently and then try your window, often it will go up and down all right. What makes a kink in it, and keeps it from raising is that somebody has pushed the window up—just gone to it and given it a jerk—and the pulley doesn't take the cord or the chain fast enough and it gets a kink.

Whatever you do, do with smooth and easy motion. Don't jerk. Don't pull and haul on things. Anything that is done smoothly and with rhythm is done more easily than when it is done with the jerk and pull method.

When you get back to your floors count the windows. I'm very sure you will have a great deal more respect for them than you have ever had before. A window does a great many things for the light, the air, the appearance, the cheerfulness of a room, but only if it is clean—the window itself, all the trimmings, the dressings on it, and all the component parts that keep us comfortable like the storm sash in the winter and the screen in the summer that admits air without flies and little bugs.



"OUTWEAR THREE COTTON OUTFITS — that's our experience with Karoll's panty-type dresses in our maximum security wards. The Karoll dress is one garment, eliminating the handling of four pieces of clothing— dress, slip, panty and brassiere"

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Note: snap-fasteners at crotch

Cheery, sturdy! Snap-fastened built-in panty

All-in-one garment, designed and tested by institutions for mental and retarded patients. Inhibits the exposure impulse, resists tearing. Slips on over head. No brassiere or other undergarment needed. Snap-fasteners at crotch aid toilet training. Pleasing patterns or 2-tones with round, V or square neckline Needs no ironing. SuperMaid sizes 12 to 62 for women; SuperLassie sizes 7 to 14 for girls. Send for swatches, brochures on garments for every need.



Amazing strength! Doesn't weaken in repeated washings, after months of use.



Patterns, colors fade-proof tested; fabric Sanforized for long lasting fit.



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Tiny, transparent particles of "Ludox" impart a unique "snubbing" action to the wax film—retard the shifting of wax particles under foot pressure. The result—added traction and added *safety* underfoot!

Try a wax containing "Ludox." You'll see how *safe* beautiful floors can be.

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Ask your maintenance man or janitor supply house for one of the many fine waxes on the market containing Ludox.®

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BETTER THINGS FOR BETTER LIVING
... THROUGH CHEMISTRY

For safety underfoot, specify floor wax made with

LUDOX®

Colloidal Silica

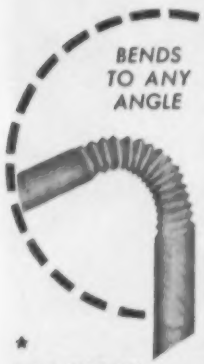
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Central Supply Standards

(Continued From Page 64)

Unknown to some central supply supervisors, and not admitted by others, is the fact that improper sterilization is the cause of more destruction of rubber gloves than any other factor. Even under the most carefully controlled conditions, sterilization is the greatest single cause of loss of elasticity and tensile strength.

Oversterilization, *i.e.* leaving the gloves in the sterilizer too long, is not the only cause of their rapid destruction. Minute quantities of air left in the sterilizer will also cause rapid deterioration of the rubber. Tests by the National Bureau of Standards have shown that as little as one part of air per thousand will affect rubber very slightly. However, when 40 parts per thousand are present, a single sterilization for 15 minutes under 15 pounds of pressure may cause a reduction of tensile strength of 25 per cent.

The National Bureau of Standards found that air left in the sterilizer could be eliminated most rapidly by temporarily opening the bleeder valves which by-pass the steam traps. One other method is that of injecting and exhausting the steam from the sterilizer four or five times. Such a process not only removes the air quickly, but also results in more rapid steam penetration of the sterile packs.

Our tests show that about 60 per cent of the gloves must be discarded because of cuts and punctures that occur in the operating room. Another 30 or 40 per cent is discarded because of tears on the cuff or fingers. Such tears may occur after only one or two improper sterilizations.

Another factor contributing to the life of rubber gloves is the quality of material when purchased. We have tested every major brand of glove on the market on several different occasions. We found few which met the federal specification requirements for breaking strength and elasticity and withstood the accelerated life tests in the oxygen bomb and sterilizer.

No brand of brown milled gloves has met these specifications. After a long and careful investigation we have been unable to prove that brown milled gloves are any less irritating than the pure latex gloves. Evidence of this comes from the fact that no government agency buys brown milled gloves. We have reports from several hospitals indicating that latex gloves have been used for several years without complaints of excessive irritation or allergic reactions. Pure latex rubber gloves will last from one to two times longer than brown milled gloves under ordinary conditions of use.

HYPODERMIC SYRINGES

Since hospitals do little or no testing of syringes as they are received, they do not always get the quality they should. Supervisors should be aware of the basic quality requirements for hypodermic syringes, which include:

1. No grind marks, pits or open air holes in the barrel or plunger.
2. Smooth operation of plunger in barrel.
3. No leakage of liquid past the barrel under pressure.
4. No leakage around tip when fitted to standard luer.
5. No breakage when syringes are subjected to sudden heat changes.
6. No residual strains in the glass owing to poor annealing.

The latest development in this field is the introduction of interchangeable syringes. Practically all the major companies are now making them, although not equally well. The great advantage of the interchangeable syringes is the fact that an unbroken barrel or plunger no longer has to be discarded, because it can be fitted with another plunger or barrel. Another important factor is that syringe plungers and barrels can be sterilized separately, thus reducing breakage.

Because interchangeable syringes are produced with much lower tolerances than the old style, more difficulty has been encountered in cleaning them. Any particle of dirt between the plunger and barrel will cause trouble. The central supply supervisor, therefore, must introduce the best cleaning technics possible when the hospital goes over to interchangeable syringes. Much of the difficulty can be overcome if syringes are rinsed off immediately after use.

CONCLUSION

This report reveals one very important fact, namely, that central supply supervisors not only must know their products, but must have an intimate acquaintance with the materials they are using. Their experiences with different products should be passed on to the purchasing department and efforts should be made to obtain products that will meet their use requirements as closely as possible.

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*Sherber, P.A.: The control of bleeding, Am. J. Surg. 86:331 (Sept.) 1953.

Indicated in postoperative bleeding associated with:
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THE S. E. MASSENGILL COMPANY, Bristol, Tennessee

The Best Homes Work With Hospitals

(*Continued From Page 78*)

clusively for the aged, but the basis for most of the applications to enter these homes was still indigency. This held true until fairly recently when modern social legislation caused great changes. With the advent of union pension plans, Old-Age and Survivors Insurance, and most important, old age assistance, it no longer became necessary for an aged person to enter a home for financial security. Applications to homes began increasingly to be caused by the inability of older people to care for themselves because of illness and infirmities and the homes were increasingly faced with the problem of medical care.

NEED FOR MEDICAL SERVICES

Progress in the medical and allied sciences also served to accentuate the need for improved medical services in homes for the aged. The discovery of antibiotics and other advances lengthened the life span so that the homes found themselves with an older group of residents who brought with them a burden of chronic illnesses that demanded treatment. These older residents of the homes needed intensive medical care not only when *in extremis* but in order to enable them to spend their increased days in comfort. The tremendous recent progress in rehabilitation further underscored the responsibility of the homes for aged to use this knowledge for the benefit of their residents.

Various homes found different solutions to these problems and nearly as many solutions were found as there are homes. They varied from the establishment of complete medical facilities in some homes to the simplest medical facilities in others. There are homes today which have incorporated within them complete, licensed and accredited hospitals. There are also homes which, at the other extreme, offer no medical care other than visits to the home by a neighborhood physician. Most important, a number of nursing homes have sought improved medical care for their residents through arrangements with neighboring general hospitals.

There can be small question that this last approach is the most efficient and economical. Examine the alternatives! Can a home make no provision at all for hospital care? Beyond doubt there is often need for hospital care for the aged and any institution for the aged which doesn't make some provision for such care is shirking its responsibility. The home which accepts and serves only the well, ambulatory aged and discharges its residents when illness strikes is not performing a satisfactory public service.

On the other hand is the institution which organizes its own complete hospital and integrates it within the home. Consider what this involves! It must set up and staff a hospital with a laboratory, an x-ray room, operating facilities, and the myriad other secondary services and equipment which are required. Then, a medical staff must be recruited. A nearly complete medical staff, exclusive of obstetrician and pediatrician, is needed, for the elderly patient can be stricken with nearly any of the illnesses to which our younger population is subject. Now, for what is all this array of talent and equipment needed? For what must we invest thousands of dollars in equipment and attempt to obtain the services, in competition with established general hospitals, of top grade medical men in this day when there is a shortage of physicians?

DON'T DUPLICATE EQUIPMENT

All this is required to give medical services to a relative handful of people! In order to perform perhaps a dozen surgical procedures a year we must have expensive operating equipment and we must expend all the effort needed to recruit and maintain surgeons, anesthetists, specialized nursing staff, and so on. Few homes for the aged have populations in excess of 200 to 300. There are a few, in large urban centers, that accommodate 900 to 1000. Even in these latter few there is little justification for setting up their own hospitals. Would a community of 900 people, adjacent to a large city with adequate hospital facilities and willing to allow the use of those facilities, set up its own hospital? The analogy is apt for these larger homes.

That these considerations are valid is shown by the fact that few homes have set up their own hospitals but many have made working arrangements with existing facilities. In general, all these arrangements serve the common purpose of assuring for the residents of the homes hospital care when it is required, with provision for return of the patients to the home when hospital care is no longer needed.

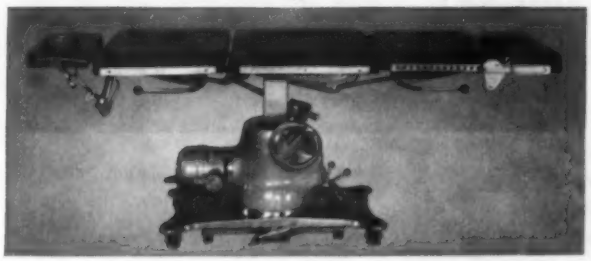
Working arrangements between hospitals and institutions for the aged also have as one of their aims making available to the homes the medical staffs of the hospitals. Homes for the aged often have difficulty in obtaining adequate medical staff for the care of their residents who need clinic care. The financial and professional rewards of giving service to an institution for the aged have not offered great appeal to the medical profession. However, through association with a general hospital, a home may be able to receive assignment of members of the hospital staff for the conduct of clinics within the home. This also opens up to the hospital staff a valuable field for gerontological research and experience in working with the chronic diseases.

A third area in which homes and hospitals are collaborators with good results is in the provision of consultation and supervision. Research projects, x-ray departments, laboratories and similar services of homes for aged benefit greatly from consultation with hospital staffs with their wider and more intensive experience. For the hospital the home offers a valuable resource for those of its staff seeking to acquire training and experience in working with older people or investigating the specialized problems of older people.

In some instances hospitals have entered into such close connections with homes for the aged that a degree of integration can be said to exist. There are cases where a home is either on the hospital's grounds or so close that the hospital supplies such secondary services as light, heat and laundry in addition to primary medical services as have been indicated. This, of course, raises the question of at what point the home loses its autonomy and becomes a branch of the hospital.

As stated earlier, there is no uniformity among arrangements between

add Greater operating ease . . . greater flexibility to hospital treatment rooms . . . with RITTER EQUIPMENT



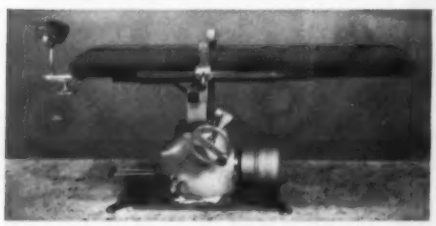
Ritter Multi-Purpose Surgery Table, Type 2-S-21

Only the Ritter Multi-Purpose Surgery Table offers the outstanding feature of a motor-driven hydraulic elevating base that is completely safe for operating room use. The exclusive Ritter base is explosion-proof . . . approved by Canadian Standards Association. A touch of the toe to the controls raises and lowers the table to the exact position required by the surgeon. The five-section top is upholstered in static conductive rubber fabric . . . the mobile base casters are also static conductive. A complete set of modern, unique, exclusive Ritter-designed side rail accessories is available for use on this table.

Ritter Proctologic Table, Type 7-S-21

The easily operated hand wheel enables a safe, smooth tilt of 50°. The table is raised effortlessly to the right examining level by a touch of the toe on the controls. The abdominal drop-out occurs automatically as table-top is tilted. Canadian Standards Association-approved explosion-proof motor base is mobile, with static conductive covers and casters. The floor lock immobilizes table when required. Adjustable headrest and proctologic knee rest make the Ritter Proctologic Table unusually flexible to meet all operating requirements. Table can be equipped with stirrups, to facilitate pelvic examinations.

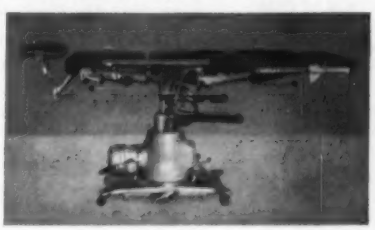




Ritter Plastic and Eye Surgery Table, Type 6-S-51.

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Ritter Specialist's Chair-Table, Type 9-S-21



The Ritter motor elevated chair-table is especially adaptable for eye, ear, nose and throat work. The energy-saving explosion-proof hydraulic base allows operating room use with complete safety . . . it, too, is approved by the Underwriters' Laboratories, Inc. The extreme flexibility of this chair-table, from chair position to full horizontal, makes it exceptionally useful in hospitals. Additional features: adjustable and removable chair-type armrests; universal arm board; combination footrest, kneerest, table extension; three restraint straps; static conductive upholstery and casters, exclusive Ritter floor lock.

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hospitals and institutions for the aged. All have their own relationships tailored to meet their needs and circumstances. I would like, however, to indicate some of the features found among various institutions at the present time:

1. The general hospital will accept without delay or question any home resident in need of intensive medical care.
2. The home holds open a specified number of beds for hospital patients who need convalescent care.
3. The clinical departments of the general hospital appoint consultants who conduct clinics at the home for its residents.
4. Interns at the hospital include a tour of duty at the home as part of their training.
5. The hospital offers consultation to the staff of the home as needed.
6. The hospital appoints the medical director or medical staff of the home.
7. Resident physicians at the hospital include in their training some time at the home.

COOPERATE ON ALL LEVELS

Arrangements such as these cannot be effected without imagination, understanding and cooperation between both the executives and boards of the institutions concerned. Investigation shows that wherever cooperation on an operational level is found there must also be a working together on the board and administrative level. In many cases the medical director of the home is on the medical staff of the hospital. In some instances the boards of home and hospital are interlocking or the president of the home is ex officio on the board of the hospital. There are also cases where the same board serves both hospital and home. Of course, the whole question of cooperation between the institutions is less thorny when both are sponsored or supported by the same central community group.

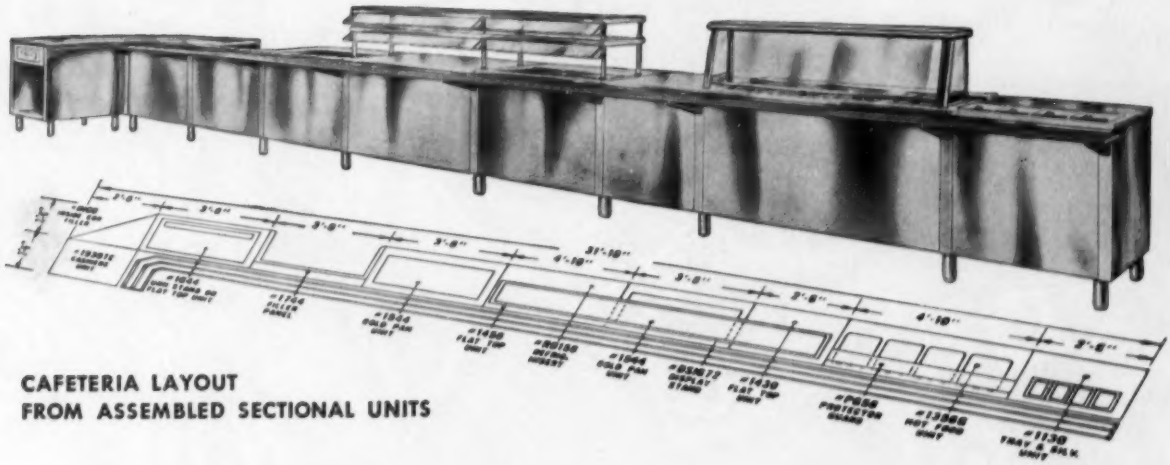
At any rate, it is only when the lay groups which are responsible for the policies of the institutions work together for the best welfare of the community without regard for vested interests in the status quo that such arrangements can be effected. Happily, many institutions today have progressive boards that make this possible and we can look forward to an increase in this fruitful cooperation between hospitals and homes for the aged.

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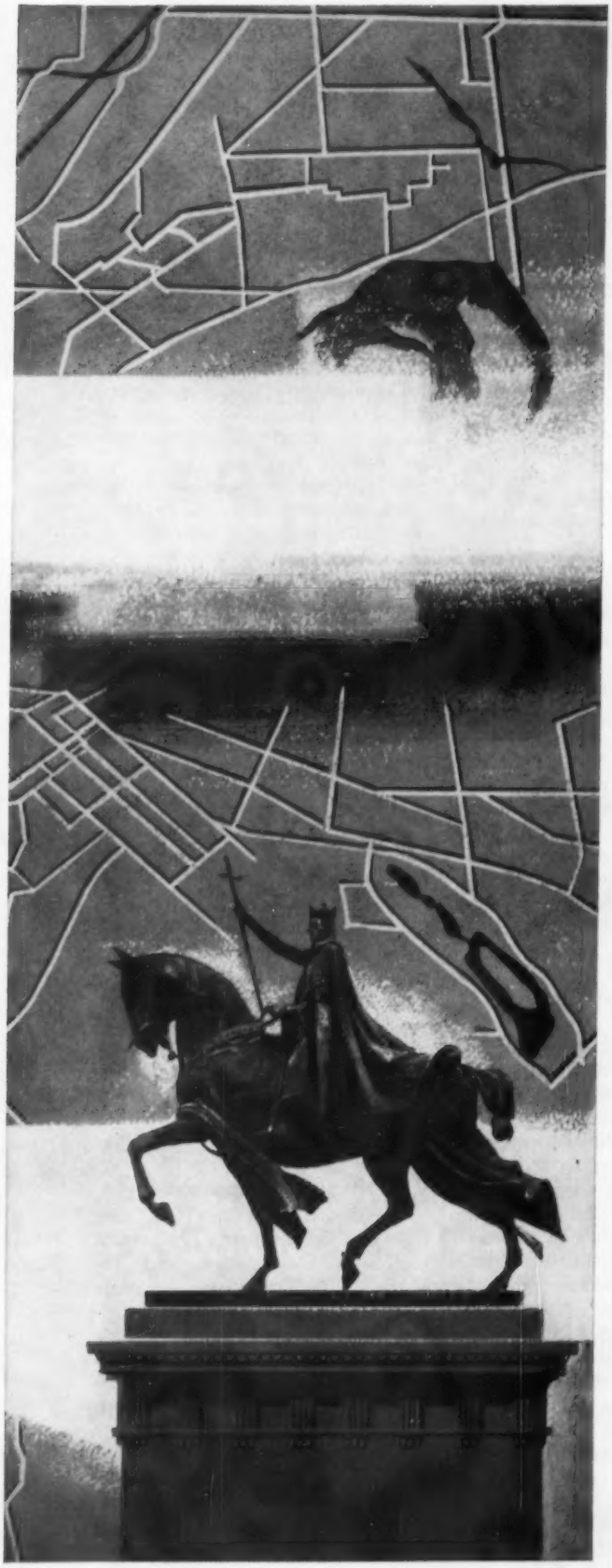
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NEWS DIGEST

Cleveland Doctors Sue Nonprofit Clinic . . . Mass Inoculation With Salk Polio Vaccine Protested . . . Announce Plans for Hospital Week Observance . . . Blue Cross Studies Catastrophic Illness Coverage . . . Spring Meetings

Cleveland Doctors Sue Nonprofit Clinic in Move Against "Hospital Practice"

CLEVELAND. — In an attempt to determine whether Ohio hospitals may employ doctors, a group of physicians here filed suit against a small, nonprofit clinic, charging the clinic was unlawfully engaged in the practice of medicine.

The suit was instituted in 1954, it was reported. The defendant clinic successfully demurred to the original petition, however, and an amended petition was filed early this year.

The clinic promptly filed a countercomplaint charging the plaintiffs with conspiracy in restraint of trade, aimed at creating a monopoly in medical services.

"It is openly understood that the precedents which the plaintiffs seek to establish in this case are intended to be used later against hospitals," said an attorney for the defendant clinic.

Plaintiffs are members of the professional services committee of the Cleveland Academy of Medicine, whose president, Dr. George L. Sackett, stated last month that the purpose of the lawsuit was to obtain "a clear-cut definition of hospital service as contrasted with professional service." The petition was filed with the approval of the academy's board of directors, Dr. Sackett said.

One member of the academy's professional services committee, it was reported, declined to participate in the lawsuit. He is Dr. W. J. Engel, vice president of the academy and a member of the staff of the Cleveland Clinic.

Among the seven physician-plaintiffs are Dr. D. D. Brannan, a radiologist, and Dr. Roland J. Whitacre, an anethesiologist who has been president of the American Society of Anesthesiologists. Plaintiffs' attorney, John Lansdale Jr., has also represented the American Society of Anesthesiologists, and has attended A.M.A. and other meetings as an observer for the society.

The complaint charged that the defendant, Hopkins Clinic, Inc., is a not-for-profit corporation duly organized under Ohio law and formed for the purposes, among others, of "providing medical and surgical treatment and charging and receiving compensation therefor from persons receiving such treatment."

Charging further that the defendant clinic "holds itself out to the public as engaged in the practice of medicine and surgery for compensation and does actually engage in the practice of medicine and surgery for compensation and prescribes, advises, recommends, administers and dispenses drugs, medicine and treatments," the plaintiffs contended that this constitutes the unlawful practice of medicine in competition with plaintiffs and other licensed physicians, who will suffer irreparable injury therefrom.

The petition seeks a permanent injunction restraining the clinic from practicing medicine or surgery or holding itself out to the public that it does or can practice medicine or surgery.

In an answering petition, the Hopkins Clinic denied that it can or does engage in the practice of medicine or surgery, and denied that it holds itself out to the public as so engaged. "Defendant avers that in accordance with its purposes as defined in its nonprofit corporate charter, it furnishes medical and surgical treatment to persons of no means, or of moderate means, and others, by providing the facilities whereby employes who are duly licensed physicians and surgeons do practice medicine and surgery," the petition stated.

Moreover, the defendant's petition charged, "All of the plaintiffs herein are members of the Academy of Medicine of Cleveland, the Ohio State Medical Association, and the American Medical Association, and as such

(*Continued on Page* 156)

Horace Cardwell Named Texas President-Elect

HOUSTON, TEX.—Horace M. Cardwell, administrator of Memorial Hospital, Lufkin, was named president-elect of the Texas Hospital Association at the 26th annual convention here, April 12 to 14.

Mr. Cardwell will succeed Boone Powell, administrator of Baylor University Hospital, Dallas, who became



H. M. Cardwell



Boone Powell

president during the convention. John G. Dudley, administrator of Memorial Hospital here, was the retiring president.

Other officers named by the association were: vice president, Bill Burton, Southwestern General Hospital, El Paso; treasurer, Bolton Boone, Methodist Hospital, Dallas; trustees: W. P. Earngey, Harris Hospital, Fort Worth; D. S. Riley, Malone & Hogan Clinic-Hospital Foundation, Big Spring, and F. S. Walters, Northwest Texas Hospital, Amarillo.

V.A. Projects Approved

WASHINGTON, D.C. — Plans have been approved for two major hospital projects and nine smaller projects, the Veterans Administration announced recently.

The two hospitals are to be at Long Beach, Calif., and at Tucson, Ariz. The Long Beach project calls for the replacement of temporary hospital buildings and the Tucson project, for a clinical addition. In the second phase of the building program, which has not yet been approved, new buildings and alterations will be added to existing structures.



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Mass Inoculations With Salk Polio Vaccine Protested as Hazardous by Chicago Doctors

CHICAGO.—As public health and school authorities, physicians and hospitals all over the country were putting into action the nationwide plan for administering the Salk polio vaccine to first and second grade children, officials of the Chicago Medical Society, which had reluctantly agreed to go along with the plan for mass inoculations, were still insisting the mass plan involved a needless hazard for some of the children.

Dr. C. K. Jones, chairman of the society's public health advisory committee, said one of the dangers was the fact that mass inoculations could cause the spread of infectious hepatitis.

Even though needles are changed after each shot, there is still danger of contamination, Dr. Jones said.

Speaking for the National Foundation for Infantile Paralysis, sponsors of the mass inoculation plan, Dr. Hart E. Von Riper, medical director, minimized the danger of hepatitis.

"Naturally, there is some danger in all inoculations, but this is overshadowed by the great good that the Salk vaccine will do," Dr. Von Riper stated. "The vaccine was given to thousands of childen [in last year's field tests] and there were no such results as members of the Chicago Medical Society warn against.

"All good doctors, whether they are doing mass inoculations or giving shots in their offices, use extraordinary precautions to see that everything is sterilized. It would be shameful to deny any child or adult the benefits of the vaccine because of the small danger present in the inoculating process."

In a letter to Dr. Jones published in a Chicago newspaper, Dr. Richard B. Capps, one of the nation's leading authorities on hepatitis, pointed out that outbreaks of hepatitis occurring in the army had followed mass inoculations.

"Since the incidence of fatal and seriously crippling polio is relatively small," Dr. Capps stated, "it is quite possible that the good done by the vaccine would be overbalanced by the harm done from spreading viral hepatitis. In my opinion there is not justification for exposing children to viral hepatitis by giving the vaccine as proposed."

Dr. Jones also said the society feared vaccine might be given to children who should not have it, such as those with kidney disease or those who were sensitive to penicillin.

Blue Cross Considers Proposal to Cover "Catastrophic" Illness

CHICAGO.—Blue Cross coverage for mental illness, tuberculosis, drug addiction and other "catastrophic" conditions is contemplated under a plan approved at the national Blue Cross-Blue Shield conference here, March 24. The proposal has now been referred to individual Blue Cross and Blue Shield plans for consideration, it was reported.

Under the proposal, subscribers would pay 20 per cent of the total cost of the catastrophic case, in a deductible provision similar to that contained in most automobile collision policies, it was explained.

The plan also provides additional benefits, including private duty nursing service, covering 80 per cent of these charges for 240 hours of service, after the first 24 hours.

The added protection would cost individuals an additional $0.75 to $1.25 a month, and $2 to $3 additional monthly for family coverage, members of the committee making the proposal estimated.

Members of the committee were Carl M. Metzger, Buffalo, N.Y.; John R. Mannix, Cleveland, and Arthur Clements, statistician for Michigan Blue Shield.

House Votes V.A. Fund to Modernize Buildings

WASHINGTON, D.C.—The House veterans committee has reported that, in the rush for new building, the V.A. has neglected to keep many of its old hospitals up to modern standards. In recommending a long-range program for renovation and replacement of the antiquated hospitals, the committee stated that 56 of the 172 V.A. hospitals are in need of major modernization. Of the 4775 buildings in use at V.A. hospitals, 1800 are at least 15 years old and 341 were built before 1900, the report showed.

The veterans committee has voted $16,885,000 to modernize the old hospitals.

Kentucky Association Names New Officers

LOUISVILLE, KY. — Sister Mary Edgar, administrator of Sharon Heights Hospital, Jenkins, Ky., was named president-elect of the Kentucky Hospital Association at the annual meeting here April 12 to 14.

Sister Mary Edgar will succeed John B. Buschemeyer of Louisville General Hospital. Edward W. Horgen, King's Daughters' Hospital, Ashland, was the retiring president.

Other officers elected by the association were: treasurer, Brig. Alvena H. Wood, Wm. Booth Memorial Hospital, Covington, and trustees: S. A. Ruskjer, Waverly Hills Sanatorium, Waverly Hills; S. A. Lott, Methodist Hospital of Kentucky, Inc., Pikeville, and Leslie Reynolds, Methodist Hospital, Henderson.

Ohio Doctors Sue Clinic

(*Continued From Page* 154)

combine and conspire with one another and with the organizations enumerated and others in a trust, the purpose and effect of which is to create and carry out unreasonable restrictions in trade or commerce, namely, to increase, and control prices, prevent competition, and create a monopoly in the furnishing of medical service to the public, all in contravention of public policy and the law of this state."

The act of filing the petition against the clinic, the defendant stated, was in furtherance of the unlawful combination and conspiracy.

The defendant clinic also asserted that it has functioned continuously in its present form and under its present charter since 1930 without interference or objection by the plaintiffs or anyone else.

"Further answering," the petition continued, "the defendant avers that other nonprofit corporations and other organizations in the state of Ohio have for some period of time furnished and do now furnish medical and surgical treatment in similar manner to this defendant, and the plaintiffs, by failing to interfere with or object to the operations, have thereby waived their right, if any, to prosecute this action against this defendant."

The clinic denied that plaintiffs will suffer any irreparable injury from any of the alleged acts of the clinic, and asked the court to dismiss the complaint.

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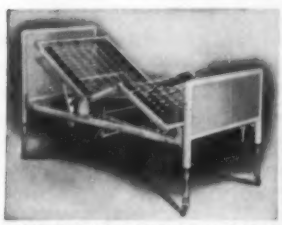
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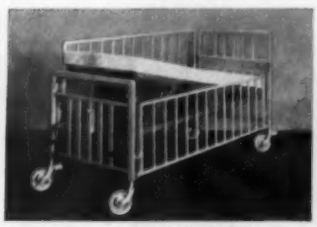
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Hospital Week Plans and Publicity Announced by A.H.A., Blue Cross, and Hospital Industries

CHICAGO. — Plans for observance of National Hospital Week, May 8 to May 14, were announced here last month by the American Hospital Association, which issued bulletins including posters, radio and television announcements, sample newspaper editorials, and other publicity material.

The Blue Cross Commission also issued publicity releases featuring observance of the 25th anniversary of Blue Cross in connection with National Hospital Week, and the Hospital Industries Association announced an expanded program emphasizing public relations activities in behalf of hospitals, beginning with promotion of National Hospital Week.

Theme for the 1955 observance, the A.H.A. announcement indicated, was "Your Hospital—a Tradition of Service." A.H.A. publicity emphasized advances in hospital care as well as growth in the number of hospitals and number of people cared for. Reduction in length of hospital stay and hospital mortality rates, technological developments, and the broadening scope of hospital service were stressed as publicity themes.

Blue Cross releases featured the fact that Blue Cross plans are actually hospital-sponsored organizations. "National Hospital Week gives hospitals a real opportunity to recognize Blue Cross publicly as an integral part of their institutions," said a statement to hospitals from the Blue Cross Commission. "Repeated efforts by Blue Cross to make its alliance with American hospitals understood by the public is only half the job. Hospitals themselves must emphasize that Blue Cross is their organization, established by hospitals to help the public pay for the care that the hospital gives."

The Blue Cross Commission urged hospital administrators and public relations directors to contact local Blue Cross plans, aiming at coordination of efforts for effective presentation of 25th anniversary and National Hospital Week publicity.

In a communication to its membership, the Hospital Industries Association said many members had urged the association to expand activities to render broader service to member companies. Directors of the association and other industry leaders outlined an expanded program, it was reported, including public relations and government relations as major association activities.

"The public relations committee will marshal the promotional resources of H.I.A. and its member companies to assist hospitals and hospital associations in nurse recruitment, promotion of National Hospital Week, care for the chronic and aged, and other vital programs," said a letter from William E. Smith, executive director. "A comprehensive program is being drafted to carry the story of the vital rôle played by the present-day hospital to the public, thus filling the void caused by an appalling lack of understanding on the part of the average citizen.

"A speakers' committee is also being appointed. Member companies will be asked to submit the names of qualified representatives who will be available to address hospital and civic meetings."

The association would cooperate with the A.H.A. and other organizations in its public relations, Mr. Smith stated.





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Accreditation Occupies Attention of Delegates to Wisconsin Meeting

MILWAUKEE. — A record breaking attendance of 425 hospital administrators, assistants, department heads, trustees and members of hospital auxiliaries heard speakers at the opening session of the Wisconsin Hospital Association meeting here March 17 explore problems of hospital accreditation. Robert M. Jones, administrator of the Waukesha Memorial Hospital, moderated this session.

Dr. Kenneth Babcock, director of the Joint Commission on Accreditation of Hospitals, opened the program. The Commission has done much to improve patient care in hospitals in the two years since it was started, he told the audience. "If one doctor on a staff makes one mistake a year, it does not seem to amount to much but if there are one hundred doctors on the staff and each one makes one mistake, it can be very serious." He urged hospitals to live up to the spirit as well as to the letter of the standards issued by the Joint Commission.

In discussing the problem from the standpoint of the administrator, Warren Von Ehren, administrator, Bellin Memorial Hospital, Green Bay, said, "The administrator must be the driving force and the leader in getting a hospital fully accredited."



Dr. Harold Coon (left) and Joseph Norby study award of merit given Dr. Coon by Wisconsin association.

C. W. Zamjahn, personnel director of a Waukesha industry and vice president of the board of trustees of Waukesha Memorial Hospital, pointed out that businessmen generally welcome outside inspections, appraisals, opinions and approvals. "As a hospital trustee," Mr. Zamjahn said, "I recognize the need for hospital standards and inspections by the Joint Commission." He added that the national commission's inspector is of great help in guiding trustees toward better patient care.

Mrs. Alta Mitchell, immediate past president of the Wisconsin Association of Medical Record Librarians and chief of the medical records department at Mount Sinai Hospital, Milwaukee, pointed out that complete, accurate medical records are an absolute requisite to any kind of effective medical audit. "A tissue committee cannot review or evaluate standards of surgery unless it has complete and accurate medical records to work with," she stated.

Dr. A. J. McCarey, president of the Wisconsin State Medical Society, also emphasized the need for good and complete medical records. "The few doctors who deliberately practice unethical medicine must be disciplined by organized medical groups," said Dr. McCarey. He further pointed out that medical societies and hospitals need the help of the Joint Commission in weeding out the unethical incompetent doctors.

In discussing patient care from the standpoint of the patient, N. J. Panella, guidance director of Waukesha high schools, asked why the average

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". . . We believe that St. Joseph's was one of the earliest of the hospitals to use this breast pad in the maternity department, where it has won favor not only with the personnel, but even more among the patients. We have had several mothers who have taken home as many as six boxes . . .!

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This shaped pad was one of those ideas the need for which had been felt for a hundred years or more, but about which little was done. Nurses and supervisors have always known that there must be a better way of stemming the flow of excess lactation in new mothers than that of using irritating gauze sponges, make-shift cut pads or lumps of cotton under the bra.

It takes hours of hospital personnel time to "manufacture" such improvised pads, and additional labor time to apply, with the results seldom satisfactory. Hospitals speedily recognized the obvious advantages of a prepared, scientifically designed pad, when we introduced it.

Aloe Takes No Credit for suggesting the shaped Breast Pad. Actually a physician friend of the Company decided that the time for such a pad was long overdue. Nature and common sense dictated the design. We merely placed the problem of production before an experienced manufacturer, with the stipulation that materials must be of the finest and that control of quality must be rigid.

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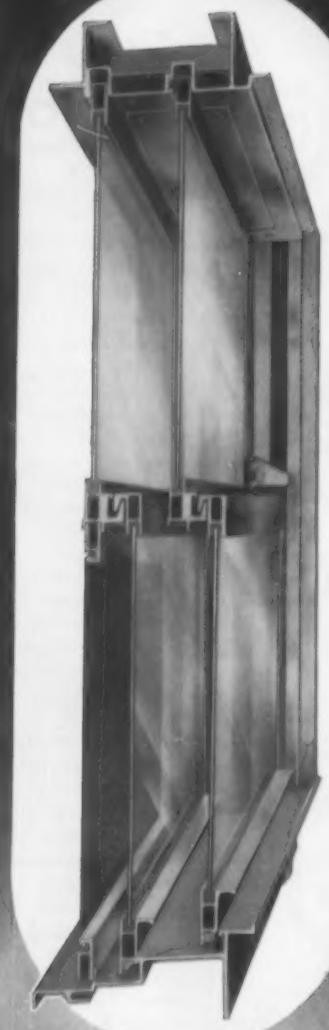
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patient never seems to see any one nurse long enough to get acquainted with her. Entirely too many people were involved in giving him nursing attention during his recent hospital experience, Mr. Panella said. "There's entirely too much secrecy surrounding patient care and I don't understand why the doctor or someone in the hospital does not explain to the patient just what's going on," he added. He suggested that both doctors and hospitals make more effort to orient a new patient who has never before been in a hospital.

Dr. James Conley, Columbia Hospital, Milwaukee, opened his discussion by stating: "We must sell ourselves and our hospitals as well as our technical and professional services." He pointed out that physicians could be of great help in explaining things to a patient. Margaret Emanuel, director of nursing, Lutheran Hospital, Eau Claire, blamed many of the present difficulties in connection with nursing care on the lack of thoroughly trained and able supervision and pointed out that the key to the use of many types of nursing personnel lies in the ability of nursing supervisors.

Dr. Paul J. Mundie, an industrial psychologist, was the featured speaker at the luncheon session. Dr. Mundie said that tensions and frustrations were inevitable in the life of a hospital administrator. He quoted from the recent articles by Dr. Ernest Dichter and Dr. Harvey Smith in The MODERN HOSPITAL to prove this point. "You must learn to get your defenses working on a nonneurotic level," said Dr. Mundie. "One good way to prepare for the inevitable stresses on your hospital job is to learn to relax." He urged hospital administrators to develop outside interests and to learn how to relax during recreational and vacation periods.

The afternoon session of this one-day meeting was devoted to reports from various regional councils in Wisconsin on the development and functioning of these regional groups. Following this last session, a buzz and forum discussion session was moderated by Everett W. Jones of the Modern Hospital Publishing Company. All speakers during the day were members of the panel.

At the conclusion of the meeting, Mary Evans, administrator of the Beloit Municipal Hospital, turned over the presidency to Stuart Hummel, ad-

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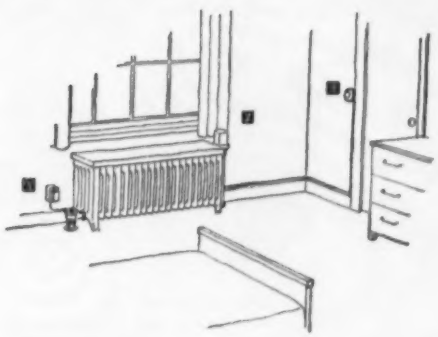
This Honeywell Round System is especially designed for existing hospitals. But, whether you're modernizing your hospital or building a new one, Honeywell has the Hospital Thermostat System to suit your particular needs.

Just call your local Honeywell office for complete information. Or, write to Honeywell, Dept. MH-5-32, 351 East Ohio Street, Chicago 11, Illinois. Ask, too, for your copy of the new booklet, "Does this happen in your hospital?"

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← *The sketch at left* shows how easily the Honeywell Round System can be installed in individual rooms in *your* hospital. The attractive thermostat (1) blends with the wall...it's connected to a Honeywell automatic radiator valve (2) and a miniature transformer (3) by a tiny wire. It's just as simple and economical as it sounds!

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ministrator of the Columbia Hospital, Milwaukee. President-elect is Riley McDavid, Kenosha Hospital. Other officers were elected as follows: first vice president, John Rankin, director of charities and institutions, Milwaukee County; second vice president, Sister Kathaline of Wausau; treasurer, Robert Griffith of the Municipal Hospital, Burlington, and trustee for three years, Dr. Harold Coon of the University of Wisconsin Hospital. During the luncheon meeting Dr. Coon was given the annual award of merit by the Wisconsin Hospital Association. Joseph Norby of Milwaukee made the presentation.

United Hospital Fund to Honor Volunteers

NEW YORK.—The husband and wife team that exemplifies a high degree of volunteer service achievement in Greater New York community service organizations will be honored as "Mr. and Mrs. New York," according to an announcement by Henry C. Brunie, of New York, and Lansing P. Shield, president of the Grand Union Company, who represent the two agencies that will present the award. Announcement of the winners will be made May 12 at the annual Awards Meeting of the United Hospital Fund.

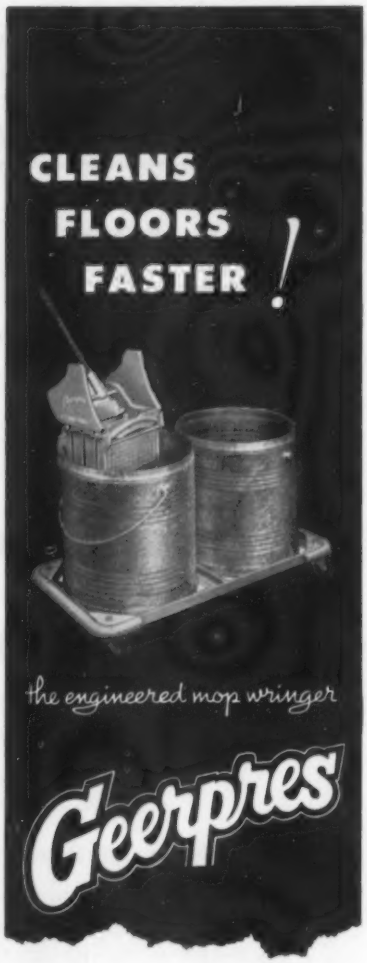
Married couples working as volunteers in any capacity will be considered for the award, Mr. Brunie said. Qualifications require that one member of the team serve in a voluntary or municipal hospital in the community and that the other be engaged in volunteer work in any one of the community service agencies in New York.

The Mr. and Mrs. New York award is part of an intensive year-round program of public education sponsored by the United Hospital Fund to acquaint New Yorkers with the services provided by city hospitals, the announcement explained.

Columbia Offers Course for Volunteer Directors

NEW YORK.—Directors of volunteer services in hospitals are being trained in the management of this department in a course given at Columbia University in cooperation with the United Hospital Fund of New York. Harvey Schoenfeld, director of Barnert Memorial Hospital, Paterson, N.J., is conducting the course.

(*Continued on Page* 166)



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Guaranteed by Good Housekeeping

(*Continued From Page* 164)

The program, the first of its kind, is being offered to some 27 students. The majority of these are directors or assistant directors of volunteer service in New York hospitals. Some commute from near-by cities and one participant arrived from Butte, Mont.

Topics covered in the course include administrative policies, organization of the department of volunteers, the department's functions and responsibilities, its interdepartmental relationships, and the psychology of the volunteer worker.

National Health Council Names New Officers

NEW YORK.—Dr. Hugh R. Leavell, professor and chairman of the department of public health practice at the Harvard School of Public Health, was named president of the National Health Council at the annual health forum here last month, and Dr. Leona Baumgartner, New York City health commissioner, was named president-elect.

Dr. Leavell succeeds Albert W. Dent, president of Dillard University, New Orleans.

In one of the principal addresses at the forum, Ellsworth Bunker, president of the American National Red Cross, reviewed the development of our unique system under which the medical and hospital professions, official health agencies, and voluntary organizations work together toward achievement of health and medical objectives.

Citing several areas that he described as "ripe for concerted action," Mr. Bunker named among these: shortages in health personnel, the appalling rise in the number of mentally ill, help for crippled and emotionally disturbed children, services for the aged and chronically ill, preparation for national emergency, and improving on the pattern of state and local health councils.

At another forum session, a panel discussed problems associated with recruiting personnel for careers in the health field. Council publications were described and, it was reported, these career publications are now being distributed without charge to all the nation's secondary schools, junior colleges, public libraries in major cities, counseling agencies, and health, civic and community groups.

In addition to Dr. Leavell and Dr. Baumgartner, other officers elected to the council were: vice presidents, Dr. Theodore G. Klumpp, president of Winthrop-Stearns, Inc., and Basil O'Connor, president of the National Foundation for Infantile Paralysis; secretary, Dr. James E. Perkins, managing director of the National Tuberculosis Association, and treasurer, Philip R. Mather, president of the American Social Hygiene Association.

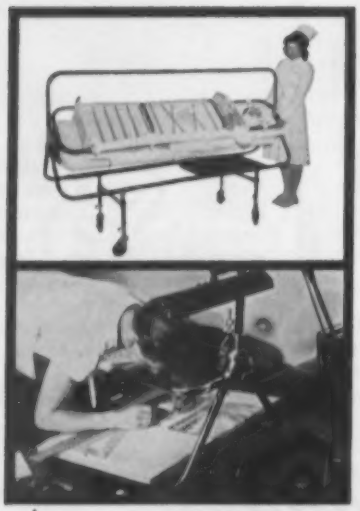
Council Names Officers

LOS ANGELES. — B. J. Caldwell, administrator of Pomona Valley Community Hospital, Pomona, Calif., was elected president of the Hospital Council of Southern California. He succeeds Sister John Joseph. Before he came to the field of hospital administration, Mr. Caldwell was a librarian. In 1946 he assumed management of the Pomona Valley library system, a position he held until he became administrator of the hospital in 1950.

John E. Paplow, administrator of Cottage Hospital, Santa Barbara, was named vice president of the council, and George E. Peale, superintendent of California Hospital, Los Angeles, is treasurer.

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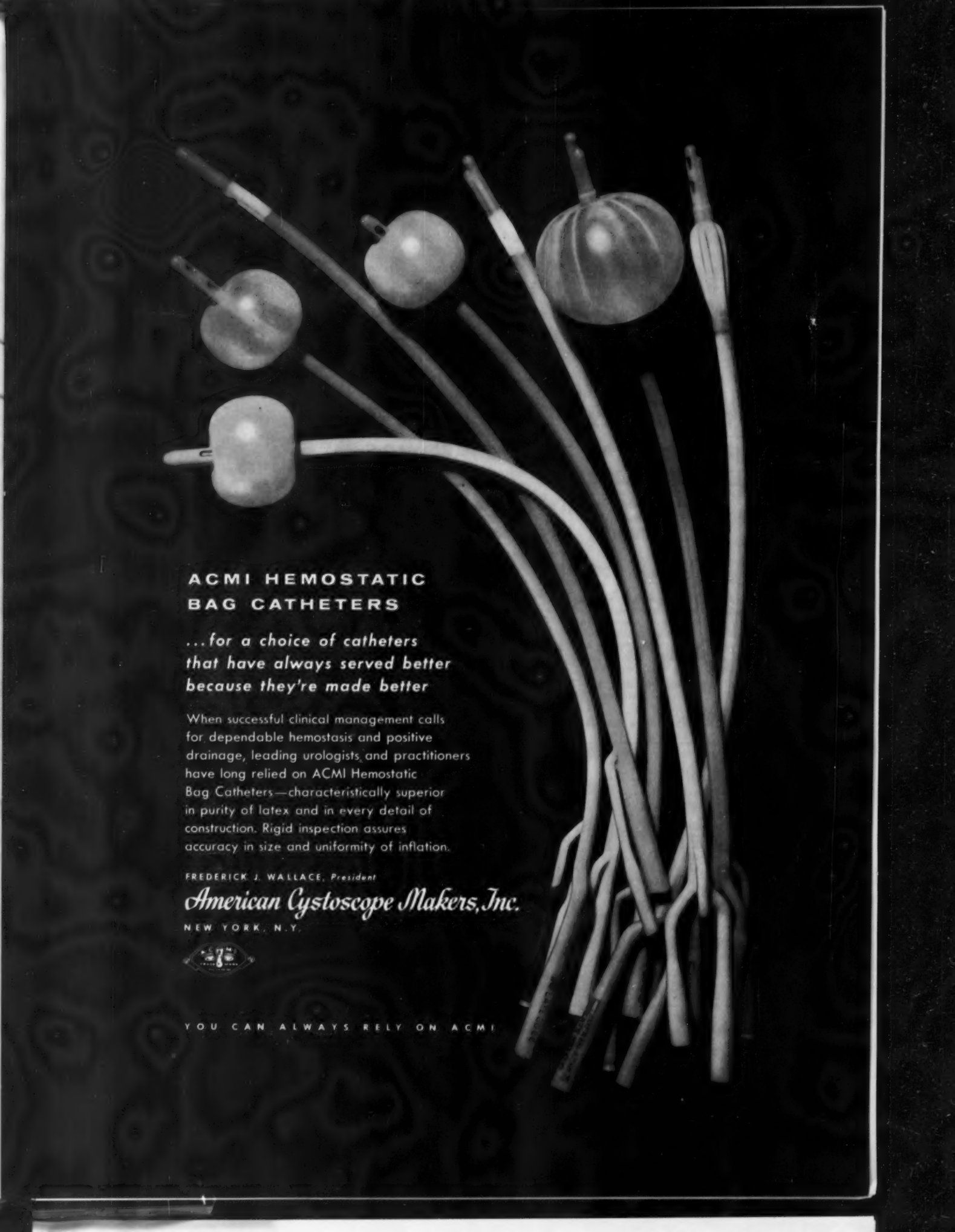
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New England Meeting Gets Down to Cases With Institutional Conferences

(*Continued From Page 62*)

even trustees. In a session on "Micro Determination in a Clinical Laboratory," the instructor reported an attendance of not only laboratory technicians, but clinical pathologists, supervisors, chemists and biochemists with a wide range of professional degrees.

This cross section pointed up what the program committee considered to be a weakness in the over-all picture. The schedule should be planned, it was indicated, to designate more clearly for what specific groups the course is intended. The course on "Building a Hospital Budget," for example, was cited as a case in point where administrators, controllers, bookkeepers, certified public accountants, and even a clerk from a 50 bed hospital were among those enrolled in the course. The material presented was of too technical a nature to be of value to all those attending. Similarly, in the course on "Supervision" the advance program failed to note whether it was aimed at the administration, the department heads, or the supervisors in the kitchen who had three people working under their direction.

"This year's conferences proved that a very definite need exists for such specialized sessions," said Mr. Viguers who is now president of the New England Hospital Assembly, "but we believe we can profit from this year's experience by establishing more clearly for whom the courses are intended and seeing to it that the instructor is well oriented in advance to the group he will be expected to teach. This may lead to even more specialization in our programming next year," continued Mr. Viguers. "There is little question that the need is even greater than we ever dreamed when we began this project. However, if this is what is needed, then it's our job to fill that need."

This idea of need and interest was borne out by administrators of hospitals in all parts of the six-state New England area. Each one questioned was generous in praise of the program and, in nearly every case, said he wished all the people whom he wanted to send and who wanted to attend could have been accommodated.

"At our hospital," said Donald Rosenberger, director of the Maine General Hospital in Portland, "it is policy for our personnel to attend instructional meetings as often as is possible for the hospital to send them. For many in this group, New York is set as the most distant point they may go. With this new addition to the assembly, we can now send a greater number oftener and be assured that they will have the best possible opportunity to become better schooled in each of their important jobs."

This sentiment was echoed in various ways by nearly every administrator approached on the subject. It appeared to be standard policy for the hospital to underwrite the expense. For many, it was the first chance for many employes to participate in such a meeting. Secretaries, dietary and maintenance personnel, accounting department and laboratory workers, long dependent on either their own groups or no groups at all for additional information, were now included in the assembly program.

Dr. Verne Kallejian, director of education of the American Hospital Association and one of the instructors

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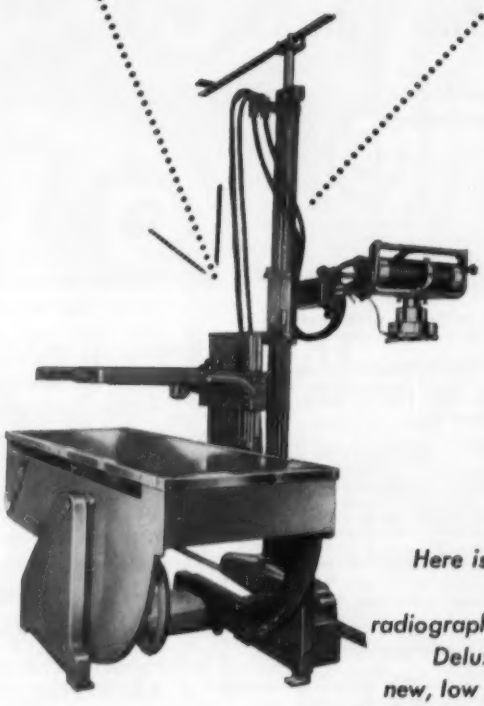
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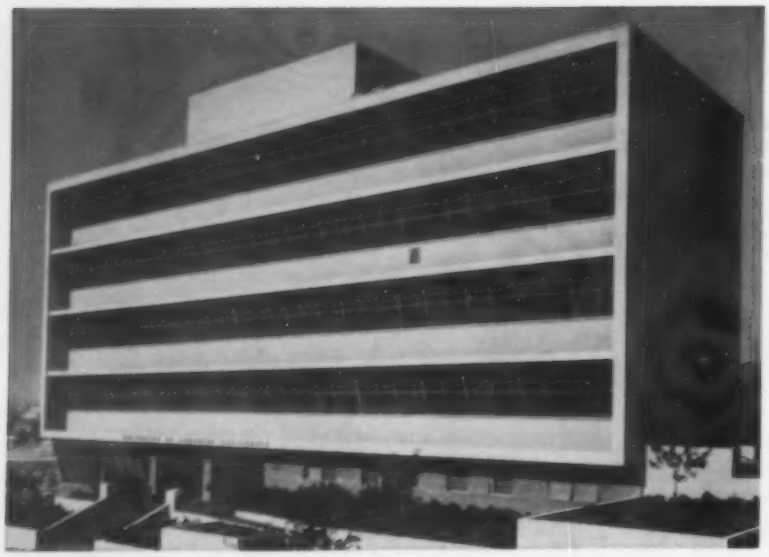


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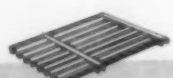
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at the conferences, was generous in his praise of the new idea. "For years," he said, "we have been concerned with the technical education of hospital personnel. This program represents a significant growth in the interest of those concerned with hospitals from the aspects of social practices, supervision, staffing and team relationships, and training a group of hospital personnel to have a greater understanding of the responsibilities it has toward the ultimate goal of patients' needs."

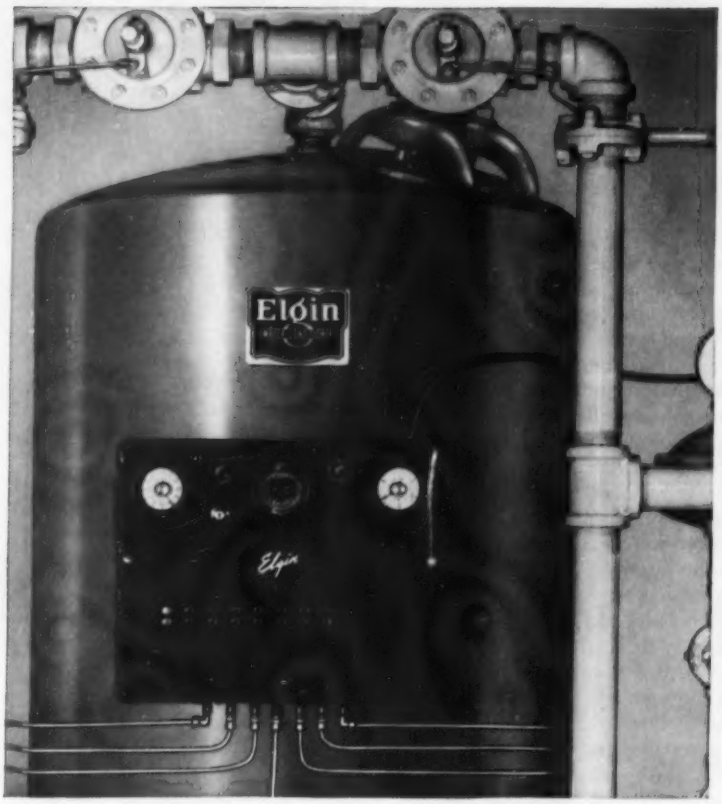
The enthusiasm shown by the instructors, the satisfaction of time well spent expressed by those who attended, and the sentiments of those in the more responsible position of hospital administration on whom the responsibility for the activities of their personnel rests would indicate that instructional conferences of the type pioneered by the New England Hospital Assembly this year are a preview of things to come in area meetings. In addition, it also establishes the fact that the need for such a program exists and can be filled with a little ingenuity, foresight and planning to benefit their personnel, and for the ultimate good of hospitals in which they work.

The assembly attracted a total of 5475 registrants from New England's 437 hospitals and hospital organizations from other sections of the country; 675 exhibitors, representing some 125 companies, presented one of the largest displays of hospital equipment ever assembled in New England.

Included in the 22 general sessions were the assembly's annual trustee institute and hospital auxiliary institute. All the general sessions and institutes attracted capacity audiences to hear leading figures in the hospital field discuss topics that included "geriatrics," "hospital relationships with specialists," and "human relations."

New officers elected at the meeting were: president-elect, William E. Sleight, director of the Roger Williams General Hospital, Providence, R.I.; secretary, Dr. Phillip D. Bonnet, administrator, Massachusetts Memorial Hospitals, Boston; and treasurer, Lois A. Bliss, R.N., administrator, Franklin Hospital, Franklin, N.H. William K. Turner, director of the Newport Hospital, Newport, R.I., and Dr. I. S. Geetter, director of Mount Sinai Hospital, Hartford, Conn., were named to the assembly's board of trustees for a three-year period.

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Isotopes and Cobalt 60 Are Not "Miracle Cures," Radiologists Report

WASHINGTON, D.C.—Radioactive isotopes have an important part to play in everyday clinical medicine and basic medical research, but they are not cure-alls or miracle treatments, a panel of roentgenologists told the Fifth Inter-American Congress of Radiology here last month.

Dr. Richard H. Chamberlain, chief of radiation therapy at the Graduate School of Medicine, University of Pennsylvania, was chairman of the panel. Dr. Chamberlain said treatments using radioactive iodine, phosphorus, gold and other materials are well established forms of therapy.

Another member of the panel, Dr. Edith H. Quimby of Columbia University, urged consideration of space and equipment for the hospital isotope laboratory, as well as the philosophy and practice of "atomic medicine." Development of isotope training programs is required, Dr. Quimby said, to ensure intelligent use of radioactive materials and fulfill requirements of radiation safety.

In an address to the congress, Dr. J. W. J. Carpender, chief of radiation therapy at the University of Chicago, said that Cobalt 60 "offers some definite advantages over conventional radiation therapy in attacking cancer, but is certainly no miracle cure."

It is unfortunate that physicians in other branches of medicine, and the general public, have come to expect miracles from supervoltage radiation, and particularly Cobalt 60, Dr. Carpender said. He pointed out severe problems inherent in cobalt therapy units, such as the large, unwieldy protective shielding that must be used.

In other addresses, Dr. T. A. Watson of Saskatoon, Sask., said betatrons are useful in treating deep-seated cancer lesions but have no obvious biologic advantages over conventional x-ray therapy, and Dr. Franz Buschke of Seattle reported that supervoltage x-ray therapy is now an essential part of the cancer fighting armament employed in radiation therapy. "While radiation in the 1,000,000 volt range has proved sufficiently superior in certain instances to be considered mandatory, and in others as advantageous although not critical, our observations still reconfirm the old experience that biological limitations more often limit the curability than technical difficulties," Dr. Buschke pointed out.



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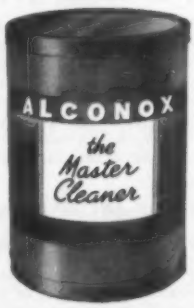
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New England Speaker Urges "Understanding" Between Hospitals, Doctors

BOSTON.—Better understanding among hospital trustees, administrators and doctors is essential to good hospital service, Dr. Leland S. McKittrick said in an address at the New England Hospital Assembly here last month.

Dr. McKittrick is a member of the American Medical Association's committee on medical practice and was one of the principal architects of the joint agreement on medical-hospital relationships approved recently by the Massachusetts State Medical Society and the Massachusetts Hospital Association.

In his address, presented at a trustee institute of the assembly, Dr. McKittrick cited a case in which three physicians were dismissed from a hospital in the Boston area. Hospital trustees took the action without consulting the medical staff, he reported. This was a severe blow to the morale of the staff and, he added, might easily have resulted in curtailed services to patients.

Discussing the problem of hospital-specialty arrangements, Dr. McKittrick stated: "We must have a continuing mechanism between the staff, the administration and the governing body."

Approximately 6000 New England hospital administrators, trustees, staff members, auxiliary members, and workers were registered for the assembly. (A major feature of this year's program, the newly developed "instructional conferences," are reported in an article on page 61.)

In another address to the assembly, Dr. Basil C. MacLean, New York City hospital commissioner, charged hospitals with "money grabbing."

In a talk that made newspaper headlines and drew some criticism from hospital people attending the assembly, Dr. MacLean said, "The average citizen is asking why the charge system of so many hospitals seems to be designed along the pattern of a clip-joint night club."

Dr. MacLean described the case of a patient in a Midwestern hospital who spent four days in bed with a cold and paid a bill of $267. "He didn't mind paying $30 a day for his room," Dr. MacLean said, "but he resented being charged 60 cents for two aspirins when he knew the hospital got them for 60 cents a thousand."

Richard T. Viguers, administrator of New England Center Hospital and newly elected president of the assembly, described the legislative program in Massachusetts that has resulted in increased payments to Massachusetts hospitals for care of indigent patients. The state now defrays "at least a sizable portion" of hospital expense for indigents, Mr. Viguers reported.

Dr. Edwin L. Crosby, director of the American Hospital Association, said in a report to the assembly that hospital costs would continue to rise. The principal reason, he pointed out, was continued advances in medical science. Dr. Crosby said improvement in hospital care of mental patients was one of the nation's foremost medical problems. "There is still one mental hospital in this country that has 13,000 patients, some of whom are in chains," he said. "The incredible fact is that though the average cost per patient per day in American nonprofit hospitals is nearly $20, the average per day in our mental hospitals is $2.68.

"One reason the American Hospital Association has never opposed providing mental care in veterans hospitals is that there they would get better treatment than in most state hospitals," Dr. Crosby stated.



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Report of the Council of Tuberculosis Committees, American College of Chest Physicians. April, 1951:

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Scheele Decries Slow Progress in Combating Mental Illness

WASHINGTON, D.C. — Mental illness continues to be a problem of "staggering magnitude," declared Dr. Leonard A. Scheele, surgeon general of the U.S. Public Health Service, at the annual meeting of the National Health Council. "Progress in this field has been discouragingly, tragically, dangerously slow," he said.

Present hospital care for mental patients offers little hope for recovery, Dr. Scheele continued. "The probability of being released alive from a mental hospital decreases rapidly after the first year. During the first year there is now about a 50-50 chance of getting out alive. After two years, the odds against being released rise 16 to 1. And by the time the patient has been hospitalized eight years the odds are more than 99 to 1. One-fourth of the patients in state mental institutions have been hospitalized for more than 16 years; one-half for more than eight years, and three-fourths for more than two years."

Among the encouraging aspects of the problem, Dr. Scheele cited the program for mental health proposed by President Eisenhower. The plan included grants to states for the support of community mental health service and increased funds for the training of additional mental health personnel.

Also criticizing the poor results of present hospital care for mental patients, a recent report from the House interstate and foreign commerce committee urged that "mental pesthouses where patients are confined indefinitely with slight hope of cure" be abolished. The emphasis in mental care should be changed from building custodial hospitals to therapy for the patients, the committee report stated.

"We have good reason to question, fundamentally, the concept of a mental hospital as the primary tool for treating the mentally ill," said Dr. Daniel Blain, medical director of the American Psychiatric Association. "The mental hospital should be merely a part of a network of community services, all of them designed to forestall or prevent hospitalization if possible or to shorten it, if not," Dr. Blain declared.



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Patient Awarded $85,000 Damages in Suit Against the Evanston Hospital

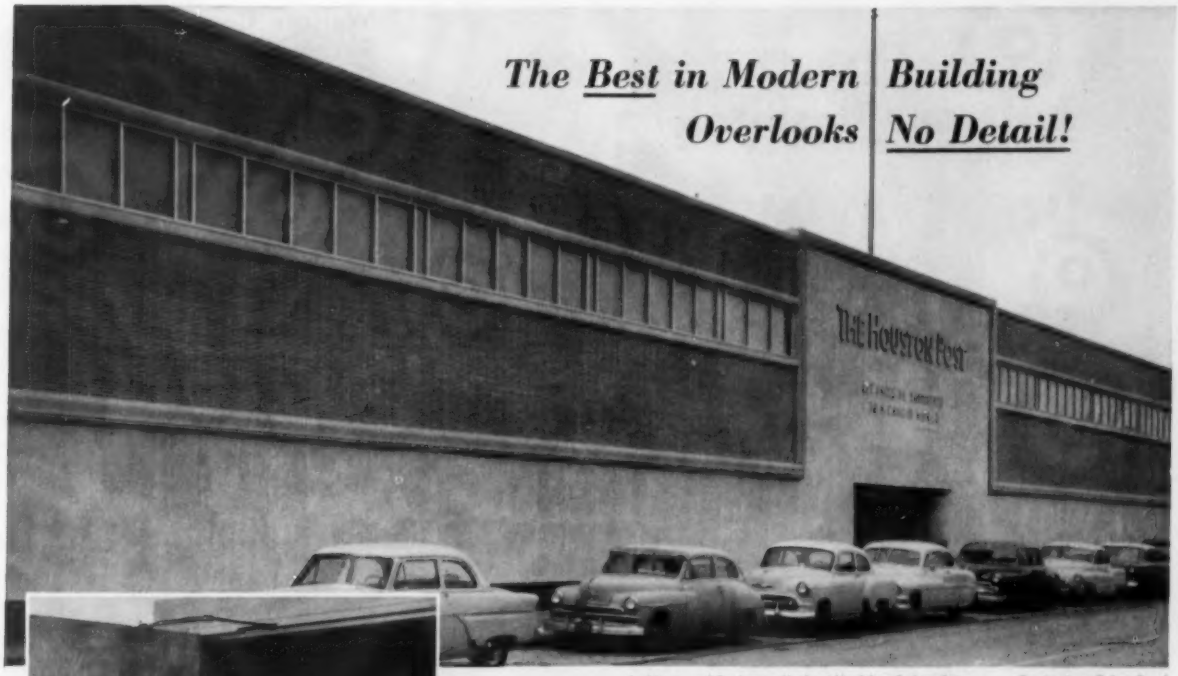
CHICAGO.—A circuit court jury here last month awarded Mrs. Julia Harvey of Chicago $85,000 damages against the Evanston Hospital, Evanston, Ill., for injuries allegedly sustained as the result of a spinal anesthetic administered at the hospital.

The jury denied the hospital's counter-claim for $21,000 in bills for medical and hospital care over a three-year period following the operation. the *Chicago Tribune* reported. According to the plaintiff's attorney, the verdict was among the largest ever assessed against a hospital in Illinois.

The plaintiff contended her lower limbs were paralyzed as the result of a spinal anesthetic administered for an abdominal operation early in 1951. She charged the hospital with negligence in administration of the anesthetic.

The hospital claimed paralysis was attributable to a spinal ailment with which the plaintiff was afflicted prior to the operation.

The trial lasted 11 days, it was reported, with a number of doctors testifying on both sides.



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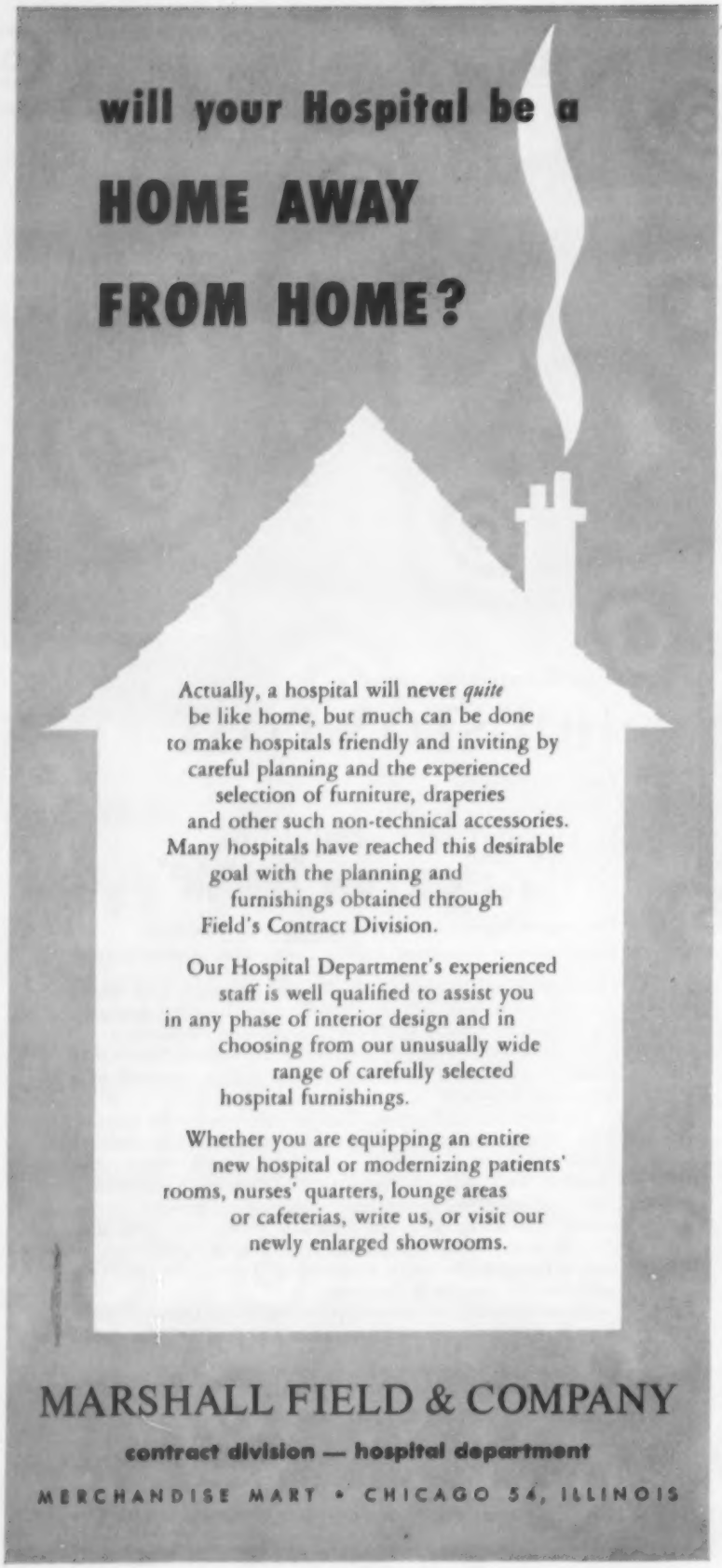
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Welfare Council Group Recommends Branch for Cook County Hospital

CHICAGO.—Establishment of a 700 bed South Side branch hospital and clinic by Cook County Hospital was recommended here last month by a citizens committee of the Welfare Council of Metropolitan Chicago, following a two-year study of the problem. The committee was appointed by the council's health division and included representatives of the Chicago Hospital Council, Chicago Medical Society, Institute of Medicine, and Chicago Plan Commission.

"The critical lack of adequate medical facilities for thousands of persons in Cook County who are unable to pay for medical care is our committee's primary concern," said Albert S. Long, chairman of the citizens committee and member of the Chicago Bar Association.

"Any expansion of present county hospital facilities should be carefully planned to meet these people's needs and at the same time ensure wise spending of the taxpayer's dollar."

Major recommendations of the committee were:

1. Construction of a new outpatient building at the present hospital to include complete diagnostic and treatment services for ambulatory patients, and diagnostic services for hospital patients, with a capacity not to exceed 400,000 visits annually.
2. Completion of remodeling and rehabilitation of present hospital buildings.
3. Abandonment of a proposed 800 bed addition to the present hospital. "There should be no expansion of basic bed capacity at the West Side location," the committee stated.
4. Establishment of a general, 700 bed hospital "readily accessible to the people in the southern and southeastern parts of Cook County." The hospital would include a 300 bed unit for long-term care and an outpatient department with capacity to handle 250,000 clinic visits annually.
5. Reorganization of present hospital facilities to provide separate units for long-term care.
6. Establishment of a pilot home care program.
7. "Cook County Hospital should study the possibilities of purchasing care of medically indigent patients in private hospitals, as a means of reducing the need for additional hospital bed construction."



The new Elks Aidmore Children's Hospital, Atlanta, Georgia. Nurses' station shows installation of Acousti-Celotex Random Pattern* incombustible mineral fiber tile.

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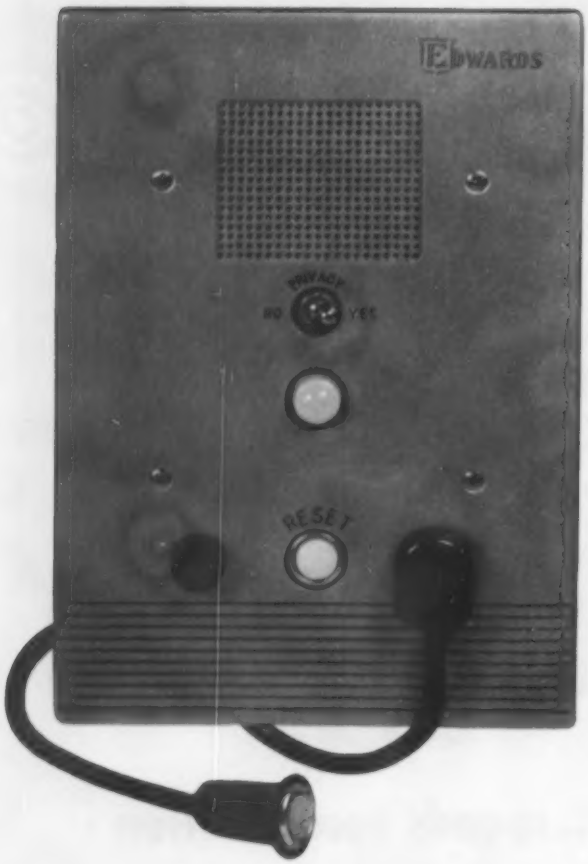
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"Public Returning to Family Doctor," Cahal Tells G. P. Academy

LOS ANGELES.—The American public is recognizing the folly and expense of jumping from specialist to specialist and has learned that the family doctor will come when he is needed, Mac F. Cahal, executive secretary, said in his annual report at the American Academy of General Practice assembly here last month.

There is increasing evidence of the deep instinctive need most people feel for a single, competent physician to supervise over-all medical care, Mr. Cahal said.

More than 5000 general practitioners attended the assembly, it was reported. General practice residency programs are now available in 139 hospitals, offering 541 approved residencies, Mr. Cahal said.

"When specialized care is required, it should be sought only after a trained family physician has made a preliminary diagnosis," Mr. Cahal stated. "For the patient to diagnose his own illness and then decide whether to call an internist, a surgeon, or a gastroenterologist is dangerous and expensive."

The academy was described as the nation's second largest medical association, with 19,000 members. During the assembly, 241 doctors were dropped from membership in the academy for failure to complete postgraduate study requirements.

"A doctor's academy membership expires every three years and is not renewed unless he can show that, during the three-year period, he completed 150 hours of approved postgraduate study. The only exceptions apply to doctors who have reached age 75 or who have practiced more than 30 years," an academy statement explained.

Health Information Group Names Officers

NEW YORK.—At the annual meeting of the board of directors of Health Information Foundation here, W. L. Dempsey, president of Sharp and Dohme Division of Merck & Co., Philadelphia, was elected chairman of the board, succeeding John G. Searle, president of G. D. Searle and Company, Chicago.

George Bugbee continues as president of the foundation. Vice presidents named at the meeting are: James Hill Jr., president of the Sterling Drug Co.; John G. Searle; George F. Smith, president of Johnson & Johnson; George Van Gorder, president of McKesson & Robbins, and Ernest H. Volwiler, president of Abbott Laboratories.

Treasurer is S. Barksdale Penick Jr., president of S. B. Penick & Co., and William A. Feirer, vice president, E. R. Squibb & Sons, was elected secretary.

COMING EVENTS

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, LaSalle Hotel, Chicago, Oct. 3-7.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Hotel Traymore, Atlantic City, N.J., Sept. 17-19.

AMERICAN HOSPITAL ASSOCIATION, Traymore Hotel, Atlantic City, Sept. 19-22.

AMERICAN HOSPITAL ASSOCIATION, Insurance for Hospitals Institute, Chicago, May 6, 7; Obstetrical Nursing Institute, Chicago, May 16-19; Public Relations Institute, Chicago, June 6-10; Pharmacy Institute, Chicago, June 13-17; Administrators' Secretaries Institute, Chicago, Oct. 31-Nov. 3.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Medical Record Librarian Training School, Chicago, May 23-27, Annual Meeting, Statler Hotel, Washington, D.C., Oct. 30-Nov. 2.

CANADIAN HOSPITAL ASSOCIATION, Biennial Meeting, Chateau Laurier Hotel, Ottawa, Ont., May 9-11.

CATHOLIC HOSPITAL ASSOCIATION, Kiel Auditorium, St. Louis, May 16-19.

ILLINOIS HOSPITAL ASSOCIATION, Annual Meeting, Springfield, Dec. 1, 2.

INTERNATIONAL HOSPITAL CONGRESS, Lucerne, Switzerland, May 30-June 3.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Annual Conference, Shoreham Hotel, Washington, D.C., Nov. 7-9.

MASSACHUSETTS HOSPITAL ASSOCIATION, Annual Meeting, Hotel Statler, Boston, May 25.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 25-27.

NATIONAL COUNCIL OF HOSPITAL AUXILIARIES OF CANADA, Biennial Meeting, Chateau Laurier, Ottawa, Ont., May 9-11.

NEW YORK STATE ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Annual Meeting, Hotel Ten Eyck, Albany, May 4-6.

TENNESSEE ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Lookout Mountain Hotel, Chattanooga, May 19-21.

TENNESSEE HOSPITAL ASSOCIATION, Chattanooga, May 19-21.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-5.

UPPER MIDWEST HOSPITAL CONFERENCE, Nicollet Hotel, Minneapolis, May 11-13.

WASHINGTON STATE HOSPITAL ASSOCIATION, Mid-Year Meeting, Winthrop Hotel, Tacoma, March 30; Annual Meeting, Davenport Hotel, Spokane, Oct. 19, 20.

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SOUTHEASTERN HOSPITAL CONFERENCE, Miami Beach, Fla., April 18-20.



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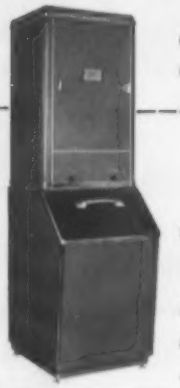
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Stamford Hospital and Bridgeport University Set Up Nursing Program

BRIDGEPORT, CONN. — A cooperative program in nursing education has been established between Stamford Hospital School of Nursing, Stamford, and the University of Bridgeport, Edgar L. Geibel, administrator of Stamford Hospital, and Dr. Henry W. Littlefield, vice president of the university, have announced.

Under the program, students entering the Stamford Hospital School of Nursing in September will take the equivalent of one semester of college study which will be distributed through the academic year. Instruction in the basic sciences will be given on the Bridgeport campus. Courses will include anatomy, physiology, chemistry, nutrition and bacteriology. Clinical instruction in nursing arts, pharmacology, medical and surgical nursing will be given concurrently at the hospital nursing school.

Full college credit will be given for each course successfully completed at the University of Bridgeport. Credits can be applied toward a bachelor's degree by students who wish to continue their studies after graduation.

N.Y.U. Offers Internship Program for Nurses

NEW YORK. — An internship program for graduate nurses, beginning this summer, has been announced by the school of education of New York University.

Dr. Martha E. Rogers, chairman of the department of nurse education, said the program will be conducted with the cooperation of the James Ewing Hospital, Memorial Center for Cancer and Allied Diseases, and is financed through grants from the Sloan Foundation.

The internship program will include advanced clinical nursing in medicine, surgery, cancer therapy, rehabilitation and team nursing, Dr. Rogers said.

"Advances in medical science are making unprecedented demands on the skills and knowledge of the nursing profession," she added. Through the new internship program, it is expected, women from various parts of the country can carry back skills and knowledge to their own communities, it was explained.



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B Mosaic Impervious Electrically-Conductive Floor Tile and Mosaic glazed wall tile, Easton Hospital Scrub-up Room.

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ABOUT PEOPLE

(*Continued From Page 89*)

Sister Rosario, D.C., has been appointed administrator of St. Vincent's Hospital for Women and Children, Philadelphia.

Dr. Amerigo P. Dell Cort, chief of professional services at Veterans Administration Hospital, Lexington, Ky., since 1952, has been named manager there succeeding **Dr. Frederick M. Cook,** who has retired. Dr. Dell Cort has served in V.A. hospitals in Pittsburgh, Bedford, Mass., and Canandaigua, N.Y.

James R. Thomas, formerly manager of the California Medical Building, Los Angeles, has been named administrator of Community Hospital Association, Wickenburg, Ariz. A graduate of the University of St. Louis course in hospital administration, Mr. Thomas served his residency in hospital administration at California Hospital, Los Angeles. Previous to that he served as credit manager of Rutland Hospital, Rutland, Vt.

Middleton T. Mustian, assistant administrator of Mississippi Baptist Hospital, Jackson, has become administrator of Memorial Hospital, Panama City, Fla.

Carl C. Helt, formerly pastor of Jaggard Memorial Church, Altoona, Pa. has been appointed administrative assistant to the superintendent of the Methodist Home for the Aged, Tyrone, Pa.

Dr. Howard P. Morgan, chief of professional services of Veterans Administration Hospital, Roanoke, Va., has been appointed manager of the V.A. hospital, Fort Lyon, Colo. He succeeds **Dr. Mansell B. Holmes,** who has resigned. Dr. Morgan joined the Veterans Administration in 1930 as medical officer at the V.A. hospital, Chicago. Subsequently he served in V.A. hospitals in St. Cloud, Minn., Memphis, Tenn., and Alexandria, La.

Sister M. Alberta of St. Mary's Hospital, Conrad, Mont., is the new administrator of St. Joseph's Hospital, Chewelah, Wash., succeeding **Sister M. Pretiosa,** who has been transferred to Mount Carmel Hospital, Colville, Wash., in charge of surgery.

Christine T. Green, R.N., has assumed her duties as administrator of Santa Rosa Hospital, Milton, Fla.

Allen M. Hicks, a recent graduate in hospital administration from the State University of Iowa, has assumed the position of administrator of Schmitt Memorial Hospital, Beardstown, Ill. Mr. Hicks has been administrative resident at St. Luke's Hospital, Davenport, Iowa, for the last year.

Stanley B. Pariso, formerly a sales representative for a drug company, has been named business manager of St. Mary's Hospital, Columbus, Neb.

Robert C. Moehn has been appointed to the position of administrative assistant II at the Milwaukee County Asylum. He will work with **Fred C. Roeseler** until approximately August 1, at which time Mr. Roeseler will assume the duties of superintendent of the infirmary. Mr. Moehn is a registered nurse and has the degree of bachelor of science in nursing from Saint Louis University. He also holds the degree of master of science in hospital administration from Northwestern University. His most recent employment has been as resident in hospital administration at Milwaukee County Institutions and Departments. He came to Milwaukee County from the Veterans Administration Hospital at Downey, Ill. where he was chief of physical therapy.



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Department Heads


Anna D. Wolf

Anna D. Wolf, R.N., director of the school of nursing and nursing service at Johns Hopkins Hospital since 1940, will retire from active service at the end of June. A graduate of the Johns Hopkins School of Nursing, Miss Wolf received her master's degree from Teachers College, Columbia University. In 1919 she went to Peking Union Medical College, Peking, China, as superintendent of nurses. There she organized a school of nursing and served as its first dean. Upon her return to the United States she was appointed associate professor of nursing and superintendent of nursing at the University of Chicago. She then accepted appointment as director of the school of nursing and nursing service at New York Hospital, New York, where she remained until 1940.

Marion S. Wood, formerly acting director of Union University School of Nursing, Albany, N.Y., has been appointed director of Albany Medical Center School of Nursing. Miss Wood is on leave of absence at Teachers College, Columbia University, where she is completing requirements for a master's degree in nursing education. Miss Wood was graduated from Garfield Memorial Hospital School of Nursing, Washington, D.C., and received her bachelor of science degree from Ohio State University.

Ralph W. Agne has been appointed office manager of Syracuse General Hospital, Syracuse, N.Y.

Frances C. Rhodes, chief dietitian of Methodist Hospital, Gary, Ind., has become director of dietetics of Aultman Hospital, Canton, Ohio. A graduate of Washington State College, Mrs. Rhodes has held dietary positions in hospitals in Washington, Utah, Montana, Idaho, Wyoming and Indiana. She is a member of the American Dietetic Association.


Dorothy Provine

Dorothy Provine, administrative assistant to the director of nursing, Michael Reese Hospital, Chicago, has been appointed associate director in charge of nursing research, Presbyterian Hospital, Chicago. Miss Provine is a graduate of the Presbyterian Hospital School of Nursing and received her master of science degree in nursing from Western Reserve University.

Mrs. Franklin Daskan has been named director of development of Woman's Hospital of Philadelphia.

Vera Meeker, superintendent of nursing service, Deaconess Hospital, Spokane, Wash., has been named nursing supervisor of Hollywood Presbyterian Hospital, Los Angeles.

Johanna Devries, R.N., has been named director of nurses of Lutheran Hospital, Omaha, Neb., succeeding Marjorie Moore. Miss Devries was formerly a missionary nurse in India and associate director of nursing service at Presbyterian Hospital, Chicago.

Carl Dell, first assistant pharmacist of Jackson Memorial Hospital, Miami, Fla., has been appointed chief pharmacist there, succeeding **Anna Shannon,** who has resigned.

Gertrude K. Clinton has been appointed director of public relations service of Gaston Memorial Hospital, Gastonia, N.C.

Grover C. Boules Jr., associate administrator of Memorial Hospital Asso-



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ciation of Kentucky, Washington, D.C., has become manager of the pharmacy and drugstore of Baptist Memorial Hospital, Memphis, Tenn. Mr. Boules has served as consultant on the development of pharmacies to the U.S. Public Health Service and has been a member of the faculty at several American Hospital Association institutes on hospital pharmacy.

Miscellaneous

Dr. Waldemar J. A. Wickman chief of the outpatient branch of the Division of Hospitals, U.S. Public Health Service, Washington, D.C., has been appointed assistant chief of the division. Dr. Wickman received his medical degree from the University of Michigan and joined the Public Health Service as a medical intern at its hospital in Norfolk, Va. He is a graduate of the Johns Hopkins University course in hospital administration, a fellow of the American Medical Association, and a member of the American Hospital Association.

Dr. Sara H. Hardwicke has been appointed secretary of the Council on Professional Practice of the American Hospital Association, succeeding **Dr. Charles U. Letourneau.** Dr. Hardwicke, who has been assistant secretary of the council since last fall, came to Chicago from Strong Memorial Hospital, Rochester, N.Y., where she had been assistant director for eight years.


Stuart C. Mount

Stuart C. Mount, a member of the administrative staff of the University of Chicago Clinics for the last two years, has been named executive director of the Nebraska Hospital Association, with headquarters in Lincoln, Neb. A graduate from the course in hospital administration at the University of Chicago, Mr. Mount has been administrator of Municipal Hospital, Platteville, Wis., then consultant for the Michigan State Department of Health.

Deaths


Clarence G. Smith

Clarence G. Smith, assistant director and controller of the Cleveland Hospital Service Association, died recently at the age of 59. Mr. Smith was one of the statisticians who originally developed the figures on which Blue Cross in Cleveland was established. At the time the Blue Cross plan was initiated, he was employed by the Cleveland Hospital Council. Mr. Smith joined the Cleveland hospital service on a full-time basis in 1935.

Dr. William H. Ordway, former physician in charge of Mount McGregor Sanatorium, Saratoga, N.Y., died last month at the age of 66. Dr. Ordway was associated with the sanatorium from 1919 to 1945 at which time the State of New York took over the sanatorium for a rest camp for returning war veterans.

Isidore Greenspan, executive director of Brooklyn Hebrew Home and Hospital for the Aged, Brooklyn, N.Y., died recently at the age of 70. Mr. Greenspan had been on the staff of the home since 1915 and executive director since 1922. He was a member of the mayor's advisory committee for the aged.

Charles M. Vollum, administrator of St. Luke's and Children's Medical Center, Philadelphia, for the last 12 years, died recently.

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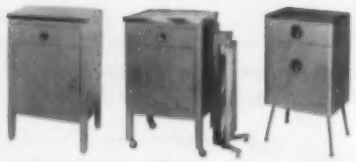
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Presbyterian Hospital Deficit Decreased in 1954, President Reports

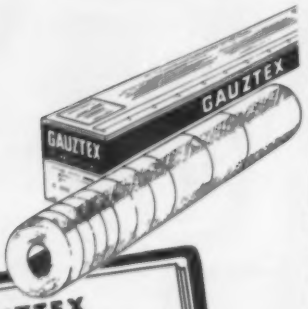
NEW YORK.—Voluntary hospitals have changed in character over the past few years and have greatly increased in their usefulness to the American way of life, said Charles P. Cooper, president of the Presbyterian Hospital at Columbia-Presbyterian Medical Center here, in his annual report.

Increased reimbursement rates for the care of the medically indigent by the Associated Hospital Service and the city of New York have brought about a decrease in the deficit from $369,000 in 1953 to $97,000 in 1954. This has made it unnecessary to increase rates charged to patients, Mr. Cooper stated.

Mr. Cooper pointed out that a greater percentage of the public is using the hospital. Admissions to Presbyterian Hospital have increased 76 per cent in the last 20 years, he said, while population during the same period has risen 15 per cent. The hospital death rate has decreased markedly. In 1872, 10.6 per cent of those admitted died, while the figure for last year was 2.16 per cent. At the same time, he continued, the average length of stay in Presbyterian Hospital has been shortened from 46 to 12 days. People come to the hospital these days for quick recovery not for prolonged illness or to die, Mr. Cooper said.

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Group Health Insurance Plans to Provide for Out-of-Hospital Care

NEW YORK.—An extended health insurance program that would cover "everyday" illnesses as well as major illnesses and allow for a free choice of doctors is being considered by New York's Group Health Insurance plan, it has been announced.

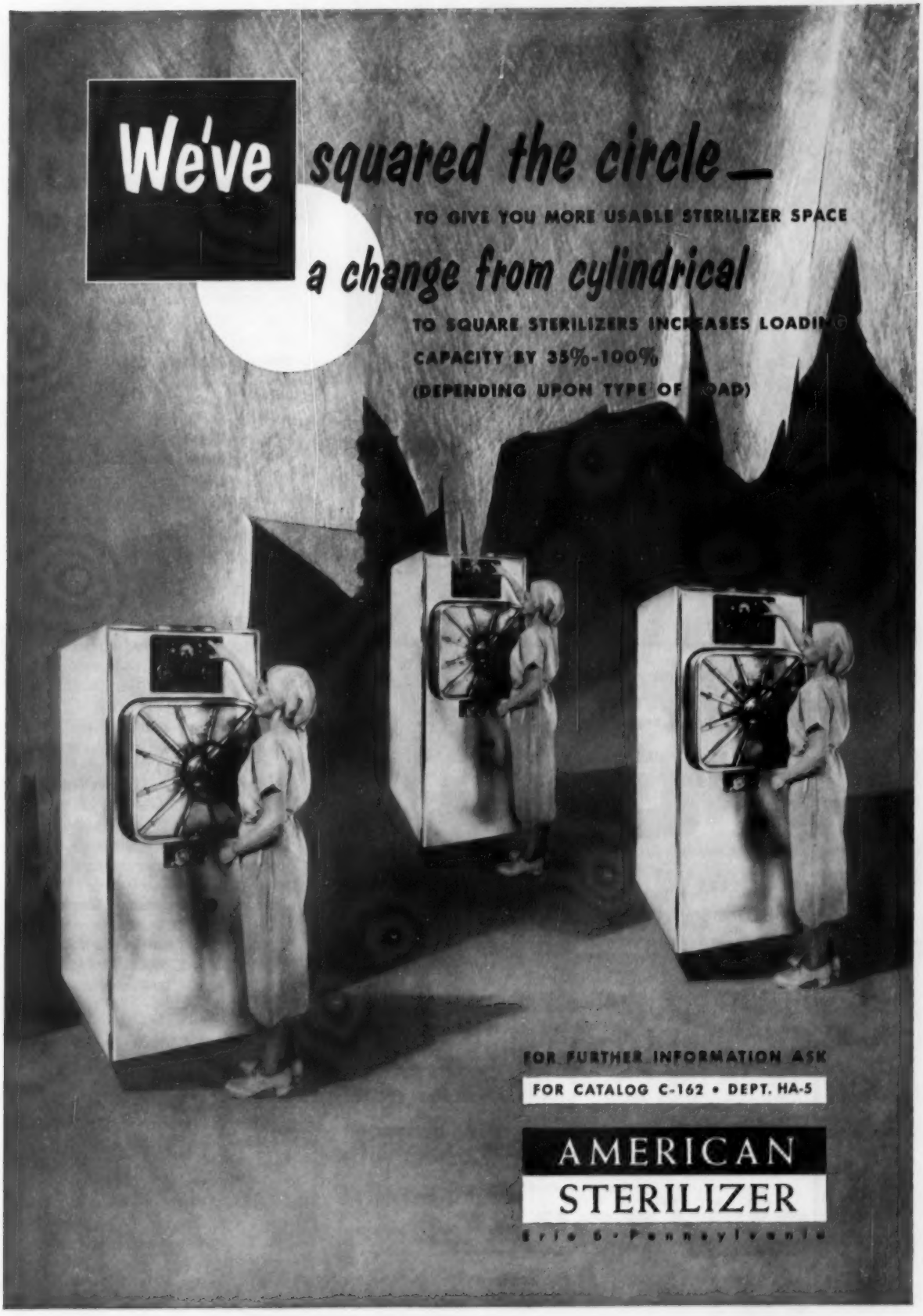
The broader coverage was outlined by Arthur H. Harlow Jr., president of the insurance plan, at a luncheon meeting here last month, sponsored jointly by the Columbia University Institute of Administrative Medicine and Group Health Insurance.

The luncheon was presided over by Dr. Harold W. Brown, director of the school of public health at Columbia University. Speakers were: Mr. Harlow, Winslow Carlton, chairman of the board of G.H.I., Dr. E. Dwight Barnett, director of the Institute of Administrative Medicine, and Dr. Alfred P. Ingegno, representing the coordinating council of the five county medical societies.

Nonprofit health insurance organizations have followed closely many of the needs indicated by labor and management representatives who testified in a recent hearing before county medical associations of the metropolitan area, Mr. Harlow said. However, it would be necessary for the individual subscriber to be willing to pay a higher premium for the increased coverage, since few companies and unions could afford increased payments for such plans, he explained.

The new coverage plan is presently before the medical societies for their consideration and will be presented to the public shortly, Mr. Harlow reported.

Mr. Carlton summarized the findings of the hearing: "The preponderant majority clearly desired complete payment by the insurance plan of the doctor bill." Many witnesses at the hearing, he said, placed dental coverage as the point of expansion next in importance to general medical care. According to the report, insurance


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Purveyors of insurance, Dr. Barnett pointed out, must understand their rôle in service plans. A number of subscribers to group practice plans tend to go to their own family doctors in addition to subscribing to plans such as G.H.I., he said. "We ought to try to develop the greatest values of both group practice and family doctor practice—they are not incompatible."

Dr. Ingegno stressed the continuing interest which the medical profession is showing in the plans. "The medical profession will continue to offer its experience, advice and leadership in realizing by voluntary methods the best that is possible in free choice medical care insurance." He also emphasized the significance of allowing the employed or union member really to have a choice in deciding whether he wants a restricted panel type of coverage or free choice coverage. This is "actually democracy in action," he said.

Catholic Hospitals Report on Nursing Graduates

ST. LOUIS.—Approximately 30 per cent of all nurses graduated in the United States last year, or 8812 nurses, were graduated from Catholic hospital schools of nursing, it was reported here recently by the Catholic Hospital Association. Margaret Foley, secretary of the Conference of Catholic Schools of Nursing, said there are 334 Catholic schools, 43 of which are colleges offering degree programs. The remaining 291 schools have three-year diploma programs under hospital control.

Total enrollment in Catholic nursing schools is 34,247 students. Of these, 226 are men students, it was explained.

"According to the most recent figures, only 36 Catholic schools of nursing have neither full nor temporary accreditation from the National League for Nursing," the report said.

An analysis of the reasons students withdraw from the Catholic schools was included in the report. Failure in theory or practice accounted for 29 per cent of withdrawals, and marriage was responsible for 23 per cent. Other reasons included dislike of nursing, personal reasons, health, personality, failure to meet school regulations, and transfer to another school.

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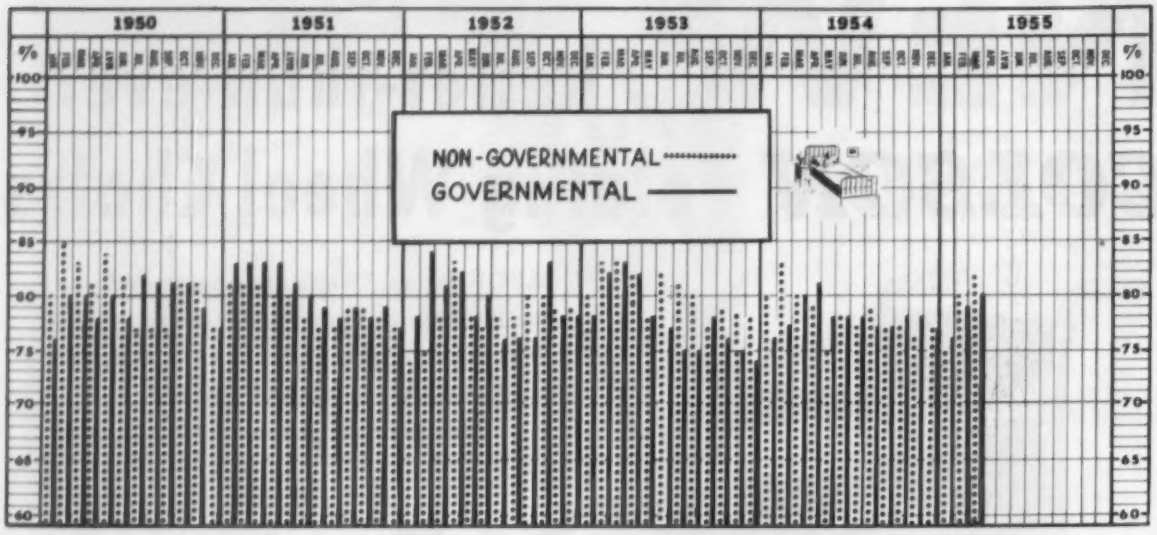
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Voluntary hospitals reported 81.5 per cent of capacity in their reports to the Occupancy Chart for the month of March. Occupancy of governmental hospitals was reported at 80.2 per cent of capacity.

New hospital construction for the period ending April 4 totaled $29,481,520; total for the year to date is $185,898,690. Construction during the corresponding two-week period last year totaled $51,360,050 and brought 1954's total at that time to $217,614,552.

Of the current 60 projects, 25 are hospitals, 25 are additions to existing hospital buildings, and the remainder are alterations and nurses' homes.

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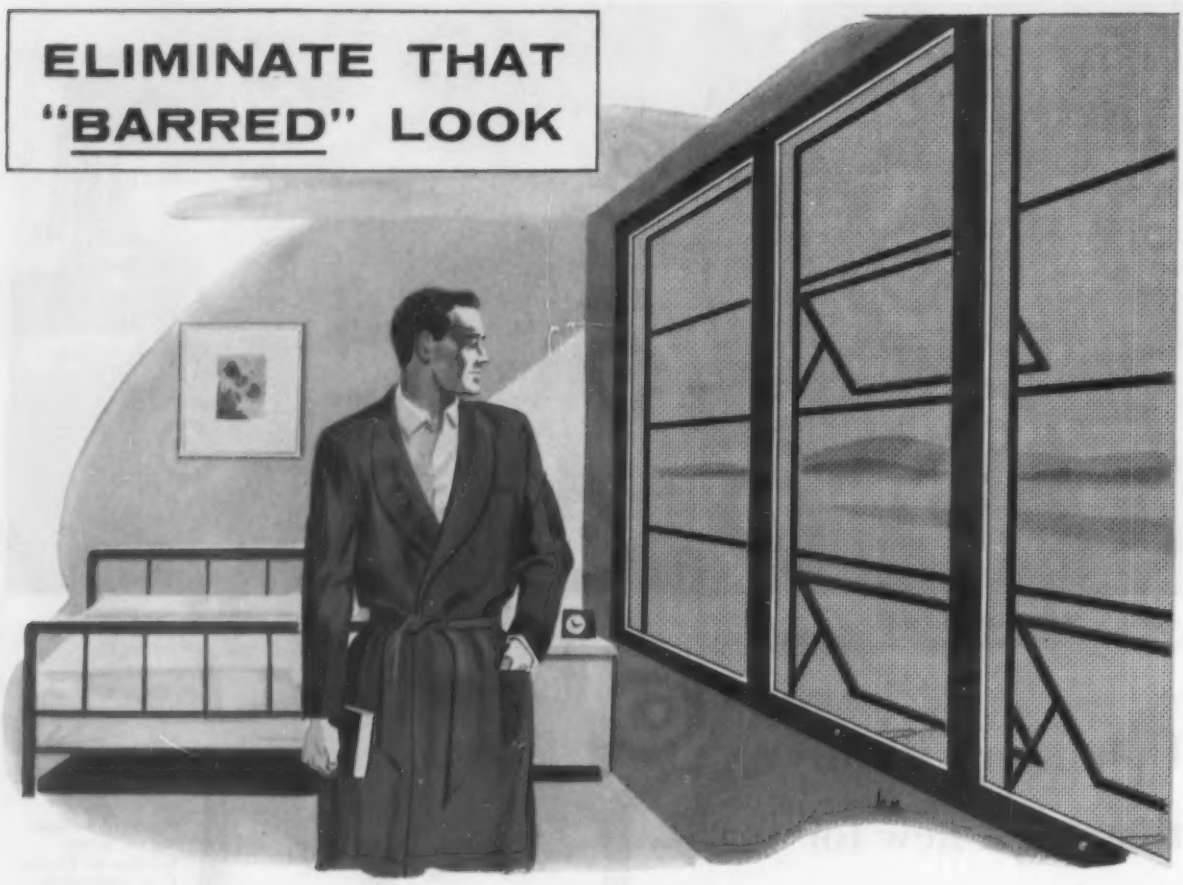
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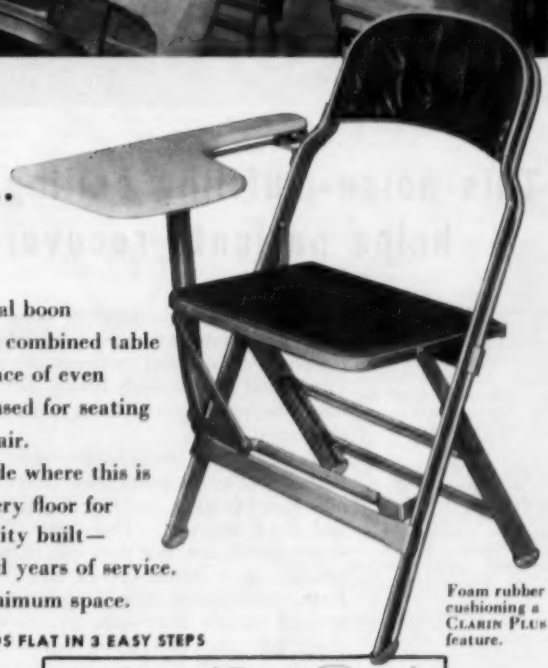
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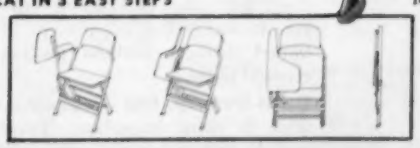
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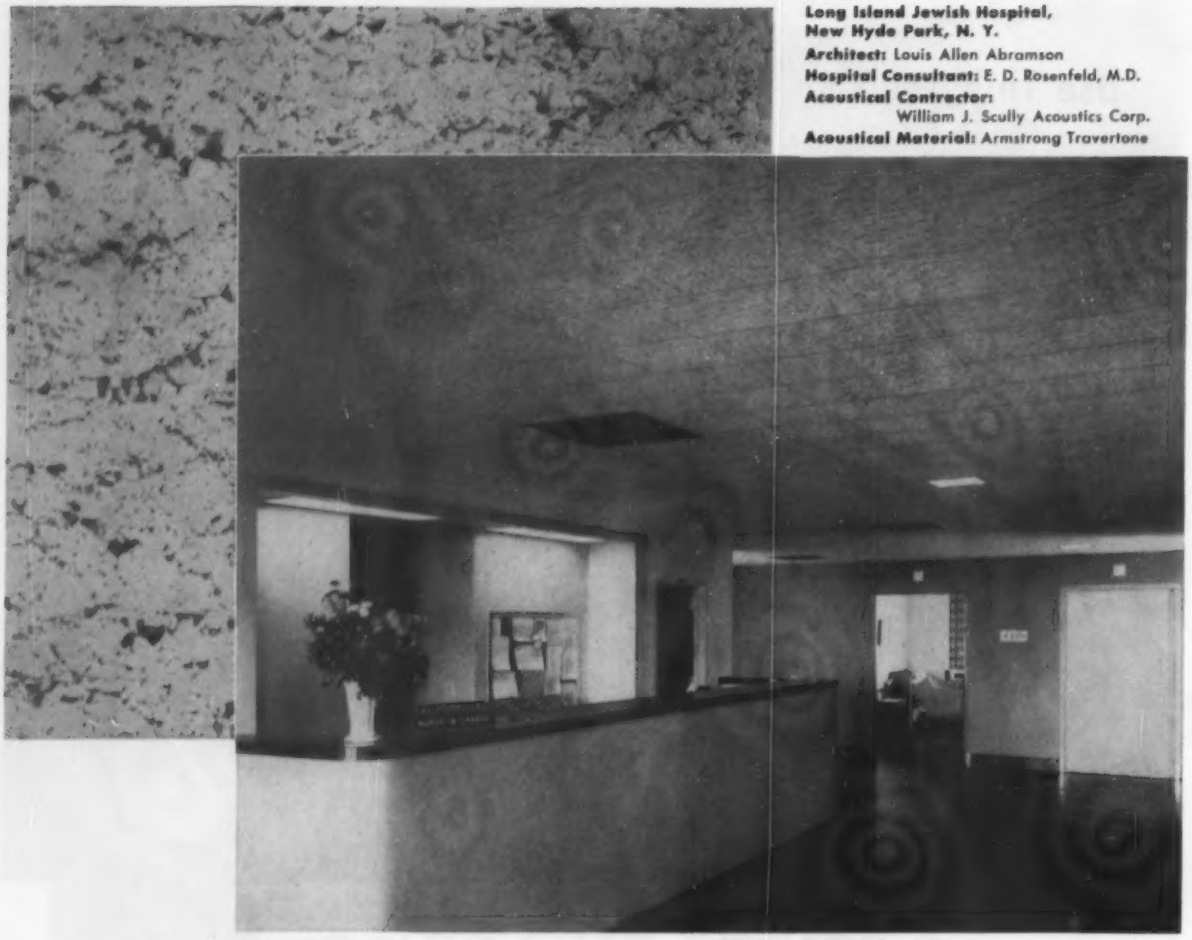
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POSITIONS WANTED

ADMINISTRATOR—Mature, male, supervisory medical technologist; A.S.C.P.; some x-ray; A.B. degree; 15 years experience in hospitals including army hospital; references, lay and medical. Apply MW 79 The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ADMINISTRATOR—33; married; B.S.; C.H.A.; 3 years administrator 50 to 60 beds, general; all purchasing; active personnel, public community and hospital relations; including radio; consider hospital to approximately 100 beds or assistant larger hospital. MW 80, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ASSISTANT ADMINISTRATOR—Young man, college graduate, with 5 years hospital experience as business manager and accountant, is desirous of relocating in similar capacity or preferably as assistant administrator, in the eastern half of the country. Apply MW 84, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—Male M.D.; residency and many years experience; available immediately; can also assist as resident hospital physician. Apply MW 85, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN and DIRECTOR OF RECREATION—Husband and wife, college graduates with seven years experience, wish employment together; can furnish excellent references. Apply MW 82, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIRECTOR—Building and grounds; 38; married; technical graduate; A.H.A.; maintenance program; 10 years experience, director of building and grounds; 250-beds up; salary open; available May 1, 1955. Apply MW 81, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ENGINEER — Chief; graduate mechanical; qualified to supervise engineering department—operation — maintenance — new construction—modernization; special talents handling mechanics all crafts. Apply MW 72, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MAINTENANCE CONSULTANT — Buildings services cleaning; available for short term assignments; an on the job survey and analysis of building services problems to determine your requirements and standards and assist toward the solution of these problems by the introduction of planned work schedules, modern time and money saving techniques and to develop efficient supervisory and working personnel. Apply MW 83, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

PATHOLOGIST—Certified clinical and anatomic pathology; age 36; category IV; associate professor; extensive surgical pathology, teaching, research, publications; desire hospital appointment; prefer academic and research possibilities. Apply MW 63, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

The Medical Bureau

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ADMINISTRATOR — Physician, well trained and experienced; M.S., Hospital Administration; two years, associate director, large teaching hospital; six years, director, 400-bed general hospital.

ADMINISTRATOR—MBA, Hospital Administration; administrative residency, teaching hospital; six years, administrator, 225-bed general hospital, during which time hospital reached new levels of professional and scientific achievements as well as financial stability.

ADMINISTRATOR—B.S., Nursing Education; M.P.H., Hospital Administration; three years, director of nursing, 200-bed hospital before specializing; four years, administrator, small general hospital.

ASSISTANT ADMINISTRATOR — M.P.H., Hospital Administration; now completing administrative residency, teaching hospital; references unite in recommending him a young man of unusual calibre.

ANESTHESIOLOGIST—Three years' training including year of research; candidate for M.S., Anesthesiology; Board eligible.

COMPTROLLER—Eight years, chief accountant and business office manager, university hospital, 800-beds; will consider assistant administratorship.

PATHOLOGIST—Diplomate, Pathologic Anatomy; Clinical Pathology; three years' full time teaching; six years, director of pathology, 300-bed general hospital.

PHARMACIST—M.S., Pharmacy; two years, assistant pharmacist, large teaching hospital; recently received military discharge.

PHYSIATRIST—Three-year fellowship, teaching center; two years, charge department, army hospital; Diplomate, Physical Medicine and Rehabilitation.

RADIOLOGIST—Three-year fellowship, university center; several years' successful private practice; prefers directorship, hospital laboratory, full or part time, with or without private practice; Diplomate, Diagnosis X-ray and Radium Therapy.

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Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATOR—B.S. Degree, New York University; M.H.A. Degree, 1952; 1 year residency, 3 years assistant director, 400-bed Pennsylvania hospital.

ADMINISTRATOR—B.A. Degree. R.N., New York, Pennsylvania; MPH Degree, 1952; experience: 4 years superintendent, 250-bed hospital, east; available.

BUSINESS MANAGER—B.A. Degree, Administration; 7 years assistant business manager, large state hospital; prefers change; any locality considered.

COMPTROLLER—B.S. Degree, Business Administration! 4 years accountant for railroad; 4 years present position, 400-bed mid-western hospital.

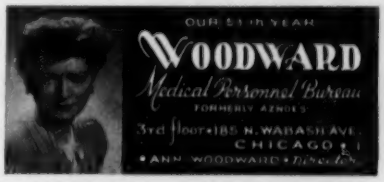
(Continued on page 200)

INTERSTATE—*Continued*

EXECUTIVE HOUSEKEEPER—Age: 45; 2 years western college; 6 months institutional housekeeping, Chicago. 12 years successful experience, 250-450 bed hospitals, east and mid-west; available June.

NURSE ADMINISTRATOR — Graduate New York hospital; 10 years O.R. supervisor; 3 years assistant superintendent, Ohio; and 8 years administrator, 85-bed hospital; considered good financier; charming personality.

PURCHASING AGENT—College graduate; 6 years purchasing agent, 300-bed hospitals, Ohio, Connecticut.



ADMINISTRATOR—B.S. Business Administration; M.S. Hospital Administration; year's administrative residency, 700-bed hospital; seeks directorship, hospitals to 100-beds; fine appearing; well-trained, competent; late 20's.

ADMINISTRATOR—Medical; degree, important school; nine years teaching medicine; five years, medical director, teaching hospital.

ADMINISTRATOR—B.Sc. Business Administration; M.H.A.; year's administrative residency, university hospital; four years, administrator 125-bed general voluntary hospital; early 30's.

ADMINISTRATOR—Woman RN; late 40's; FACHA; 17 years administrative experience, 12 in same 80-bed general hospital; seeks similar appointment; east only.

ASSISTANT ADMINISTRATOR — 29; B.S. Business Administration; M.S. Hospital Administration; year's administrative residency, 800-bed teaching hospital; fine appearance; well prepared; seeking further experience in large hospital.

CYTOTECHNOLOGIST—Female; single; 30's; training received Cornell University; 8½ years experience, 6 as chief technician, gynecology and pathology lab, large university hospital; 1½ years experience teaching and research assistant, eastern university; seeks chief or teaching position; midwest only.

DIRECTOR OF NURSES—M.S.; Administration in Schools of Nursing, Catholic university; single; 50's; 6 years experience as operating room supervisor; 7 years teaching experience; 8 years, instructor and assistant director of nurses, 250-bed hospital; 1½ years, same capacity, 350-bed hospital; seeks directorship or assistantship; Georgia only, prefer near Atlanta.

EXECUTIVE HOUSEKEEPER—Late 30's; 8 years experience, executive housekeeper, 80-bed general hospital and ancillary buildings; seeks similar position, small hospital preferred, southwest only.

MEDICAL RECORD LIBRARIAN — Registered; early 30's; 13 years experience, 12 as assistant, 600-bed general hospital; seeks chief position, Washington, D.C., only.

NURSE ANESTHETIST — Registered; 50's; nearly 16 years anesthesia experience; prefer 8 hour shift, obstetric anesthesia only; deep south only.

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POSITIONS WANTED

WOODWARD—*Continued*

PATHOLOGIST—38; trained university hospitals; Board eligible, anatomical and clinical pathology; four years' private general practice before specializing; currently associate pathologist, 250-bed hospital.

PATHOLOGIST—Diplomate, pathologic anatomy Board qualified, clinical pathology; experience includes four years, assistant pathologist, three years chief pathologist, very large teaching hospitals; late 30's.

PHYSICAL THERAPIST—Female, registered, late 40's; M.A. in Physical Education; 25 years experience, 12 as chief, various general and army hospitals; California only; available November 1955.

PURCHASING DIRECTOR—A.B.; excellent experience in credits and accounting; 5 years Lt. Commander, USN; 3 years assistant purchasing director, large university; 5 years purchasing director, very large university hospital; member, Purchasing Agents Association, American Hospital Association; middle 30's; available 2 months; seeks hospitals, 400-beds up.

RADIOLOGIST—30; Diplomate, diagnostic and therapy; trained university hospitals; currently radiologist, 300-bed hospital; seeks directorship, department radiology, hospital in south, southeast or southwest.

POSITIONS OPEN

ANESTHETIST—Registered nurse; New 250-bed, well equipped general hospital; department directed by medical anesthesiologist, cooperative medical staff and personnel; good personnel policies; salary depends on experience, minimum $414.00 with periodic merit raises. Apply, Director, McLaren General Hospital, 401 Ballenger Highway, Flint 2, Michigan.

ANESTHETIST—Nurse; position open, excellent opportunity; 275-bed hospital. Apply Robert M. Murphy, Administrator, Lima Memorial Hospital, Lima, Ohio.

ANESTHETIST—Nurse; for an old established group; good starting salary and permanent position. Apply The Sugg Clinic, Ada, Oklahoma.

ANESTHETISTS—3 nurse anesthetists to increase staff; approved A.A.N.A. training school; good working conditions; medical anesthesiologist in charge of department. Apply Director, Department of Anesthesiology, Lancaster General Hospital, Lancaster, Pennsylvania.

ANESTHETIST — Nurse; neded for 87-bed general hospital; salary open depending on qualifications; full maintenance allowed; also needed are general duty nurses straight shift, salary $230 beginning with complete maintenance and single room in nurses' home. Apply Superintendent, Memorial Hospital, Rawlins, Wyoming.

ANESTHETIST—Third anesthetist wanted in approved 184-bed general hospital in city of 25,000; regulated hours and good working conditions; 4 weeks paid vacation; paid sick leave; salary according to qualifications; minimum $400 per month, plus full maintenance; living accommodations in nicely furnished nurses' home. Apply to Trinity Hospital, Minot, North Dakota.

DIETITIAN—Full charge 86-bed children's hospital; excellent salary, 40 hour week, vacations, sick leave, and 13 holidays each year; meals, retirement, insurance benefits and living quarters available. Apply Business Administrator, Northern Indiana Childrens Hospital, 1234 Notre Dame Avenue, South Bend 17, Indiana.

DIETITIAN—Head; to supervise entire dietary operation in one of Detroit's three city-owned hospitals; 700-1200 beds; requires degree, internship and supervisory experience; salary $5350—increments to $6048. Apply Detroit Civil Service Commission, Room 612, Office Section, City-County Building, Detroit 26, Michigan.

DIETITIANS—Two; plan special diets; instructs patients; checks trays; some teaching of student nurses; salary start $300; 2 weeks vacation; 6 holidays; social security; we pay for hospitalization insurance and life insurance; free medical services; sick leave; retirement plan; 44 hour week now, will be 40 hour week as soon as staff adequate. Apply Personnel Director, Rochester Methodist Hospital, Rochester, Minn.

(Continued on page 202)

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WITHOUT OBLIGATION, please send information about best way to take care of floors made of: .....

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City.....State.....

My Name.....Title..... MH-3

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DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Full charge ADA for 135-bed hospital fully approved. Apply The Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—Chief; ADA member, 306-bed hospital with large clinic and full-time medical staff of 82; good salary and good personnel policies. Apply Administrator, Geisinger Memorial Hospital, Danville, Pennsylvania.

DIETITIAN—Assistant to chief; general hospital for men, women and children; duties involve therapeutic diet planning, patient contact, assist in general supervising and some tray checking. Apply The Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

DIETITIAN—Administrative; A.D.A. Member; 200-bed pediatric hospital with specialized teaching program for student nurses, and allied medical professions; expanding facilities provide excellent opportunity for advancement. Apply Personnel Department, Children's Hospital, Columbus, Ohio.

ENGINEER—Chief; man 25 to 50 with engineering degree or equivalent experience; to supervise maintenance of equipment, buildings, grounds; 300-bed hospital; salary open. Apply Decatur and Macon County Hospital, Decatur, Illinois.

HOUSEKEEPER — Executive; 275-bed voluntary, non-profit hospital, with new and old section; renovation program; must have administrative and teaching ability. Apply Administrator, Woman's Hospital, Detroit 1, Michigan.

INSTRUCTOR—Nursing arts; 300-bed modern southern hospital; degree and experience necessary; excellent personnel policies under County Board of Education; admit one class a year, 100 students in school. Apply Director School of Nursing, Mound Park Hospital, St. Petersburg, Florida.

INSTRUCTORS—Clinical; for expanding modern hospital with temporary JCAH accreditation; attractive salary and personnel policies. Apply Director of Nurses, Allen Memorial Hospital, Waterloo, Iowa.

INSTRUCTOR—Clinical operating room; 250-bed hospital, NLN fully accredited school of nursing; liberal personnel policies; Apply Director of Nursing, Evangelical Deaconess Hospital, St. Louis, Mo.

INSTRUCTOR—Assistant Nursing Arts; for 502-bed hospital in Philadelphia area; salary based on qualifications of applicant; automatic salary increases; 40-hour week, 28 days vacation, 14 days sick leave; Blue Cross plan available; teaching duties only; opportunity to pursue additional university courses. Apply Director, School of Nursing, Cooper Hospital, Camden, New Jersey.

LIBRARIAN — Opportunity for aggressive young registered record librarian with 3 to 5 years experience as chief record librarian in medium to large hospital to be chief at 870-bed midwestern teaching hospital; opportunity to learn punch-card methods and microfilming routines; salary open; please furnish references on reply. Apply MO 101, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LIBRARIAN — Registered medical record; to head department of 275-bed, voluntary, non-profit J.C.A.H. approved hospital; department requires organizational and administrative ability; active medical record, medical audit and tissue audit committees. Apply Administrator, Woman's Hospital, Detroit 1, Michigan.

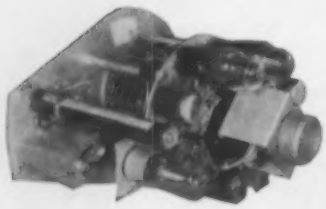
LIBRARIAN—Medical record; 133-bed hospital with 40 beds being added; salary commensurate with experience, qualifications, and responsibility. Apply Mr. H. B. Lehwald, Administrator, War Memorial Hospital, Sault Ste. Marie, Michigan.

LIBRARIAN—Medical records; qualified librarian needed or a graduate nurse who has had a course in typing with knowledge of medical records requirements, cross-indexing and filing. Apply Administrator, Plummer Memorial Public Hospital, Sault Ste. Marie, Ont., Canada.

(Continued on page 204)

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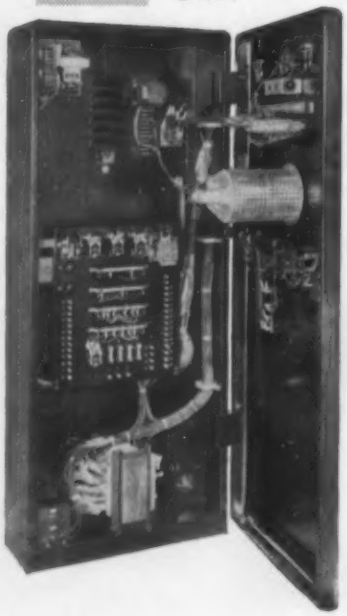
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POSITIONS OPEN

MISCELLANEOUS—"HOSPITAL ADMINISTRATOR—WANTED." For accredited general hospital being expanded from 160 to 250-beds; expansion program nearing completion; large midwest city; present administrator retiring; application and qualification resume mailed upon request. Apply MO 103, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

MISCELLANEOUS — Surgery-Supervisor $350.00; R.N. Scrub Nurse $300.00; Undergraduate—qualified $250.00; Photo with application. Apply B. Caldwell, 2406 S. Hoover, Los Angeles 7, California.

MISCELLANEOUS—Director of Nurses and Clinical Supervisor; for 100-bed general hospital with school of nursing; located in beautiful section of southwest Virginia; excellent salary; private apartment. Apply Administrator, Pulaski Hospital, Inc., Pulaski, Virginia.

NURSE—Registered charge; $300.00 to start; general duty, graduate or undergraduate; immediate if qualified; photo with application. Apply B. Caldwell, 2406 S. Hoover, Los Angeles 7, California.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40 hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Head and graduate staff; for modern 300-bed expanding general hospital located in an attractive cultural city with educational advantages; all shifts, 44 hour week, excellent living quarters, periodic increases and opportunity for promotion, salary commensurate with qualifications and experience, paid vacations, sick leave, and holidays. Apply Director of Nursing Service, Memorial Hospital, 1501 Van Buren Street, Wilmington, Delaware.

NURSES—Registered; positions available for general duty, operating room, qualified obstetrics, pediatrics and tuberculosis; living-in facilities available; average 44-hour week, 11 holidays per year, sick leave on indefinite accumulation basis; free hospitalization, one free meal while on duty, 8-hour day, laundry $4 per month, salary depending on qualifications. Apply Superintendent, Lafayette Charity Hospital, Lafayette, Louisiana.

(Continued on page 206)

NURSES—Registered; two, for 50-bed tuberculosis hospital in Indiana college town; Excellent salary and working conditions; Complete maintenance, liberal vacation and sick leave. Apply Superintendent, Smith-Esteb Hospital, Richmond, Indiana.

NURSES—Registered; Massachusetts General Hospital, Boston, Massachusetts; excellent clinical facilities, opportunity for advancement and attendance at local colleges; liberal personnel policies. Apply Director of Nurses for further details.

NURSES—Graduate; two; if interested contact Medical Director, Florida State Hospital, Arcadia, Florida.

NURSES—Operating room; at Medical Center; start $270; increases at 6 months, 1 year and 2 years; overtime premium pay; paid vacation; 6 paid holidays; sick leave; social security; we pay hospitalization insurance, life insurance, retirement annuity. Apply Personnel Director, Rochester Methodist Hospital, Rochester, Minnesota.

NURSES—Operating room; 300-bed hospital; 40-hour week; all cash salary; special consideration for experience and advance preparation; bonus for "on call"; liberal personnel policies, including social security, plus a retirement plan. Apply, Director of Nursing, Mercer Hospital, Trenton 8, New Jersey.



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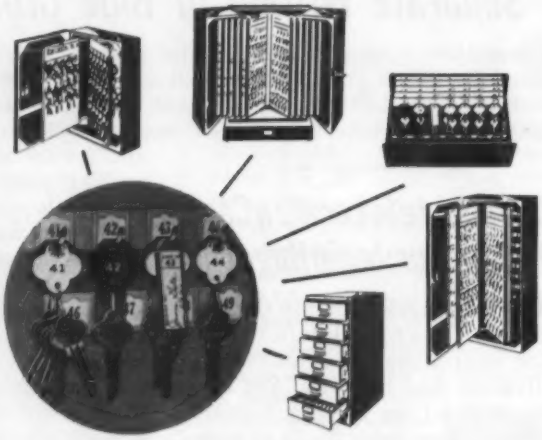
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NURSES—Registered; for operating room and general floor duty. Apply, Wooster Community Hospital, Wooster, Ohio.

NURSES—General duty; for expanding 350-bed hospital with varied services and school of nursing, located near university; starting salary $250 monthly with regular increases and differential for evening and night assignments; favorable personnel policies include 40-hour week, liberal vacation, sick leave, and other personnel benefits. Apply Director of Nursing, Madison General Hospital, Madison, Wisconsin.

NURSES—Registered staff; immediate appointments; 511-bed newly enlarged and finely equipped general hospital; duty assignments in medical, surgical, pediatrics, psychiatric, obstetrics, or contagion units; northeastern Ohio stable "All American City" of 120,000; in center of area of recreational, industrial, and educational friendly activities; living costs reasonable; within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania; friendly, cooperative work relations and conditions; progressively advanced personnel policies. Starting salary $240.00 per month with four merit increases; paid vacation, sick leave, recognized holidays, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

NURSES — Operating room; immediate appointments; 511-bed newly enlarged and finely equipped hospital; ten operating rooms now completed; northeastern Ohio stable "All American City" of 120,000; in center of area of recreational, industrial and educational friendly activities; living cost reasonable; within pleasant driving-distance advantages of metropolitan Cleveland and Columbus, Ohio, and Pittsburgh, Pennsylvania; friendly and considerate working associates and conditions; progressively advanced personnel policies; starting salary $240.00 per month with four merit increases; paid vacation, sick leave, recognized, premium pay, sickness insurance and hospitalization program, retirement. Contact Director of Personnel, Aultman Hospital, Canton, Ohio by letter or collect telephone 4-5673.

NURSES—Graduate registered staff; in-service education; liberal personnel policies; rotating shifts; starting salary $300. Apply Nursing Supervisor, Polio Center, 1801 Buffalo Drive, Houston 3, Texas.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSES—Registered; for operating room and general floor duty. Two general floor supervisors—one for 3-11 and one for 11-7. Apply, Martinsville General Hospital, Martinsville, Virginia.

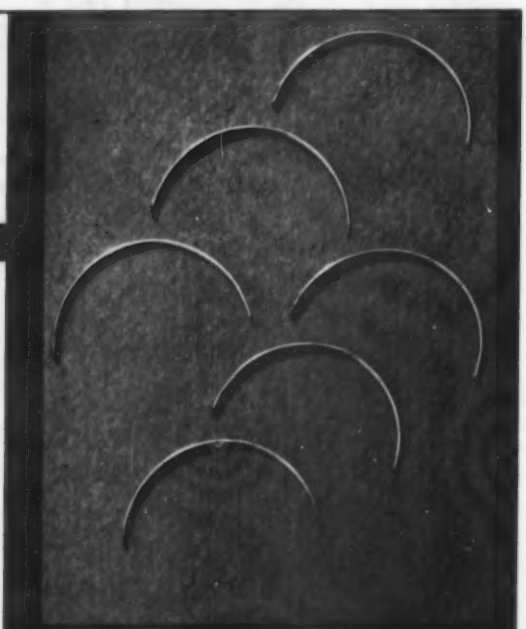
NURSES—General staff; modern 30-bed hospital overlooking St. Croix River, 20 minutes from St. Paul, Minnesota; oxygen piped to all rooms; 40-hour week, paid vacation, sick leave and holidays; salary $250-$280, extra for relief and night duty. Apply Administrator, Hudson Memorial Hospital, Hudson, Wisconsin.

NURSES — Psychiatric head; salary scale $4020-$5460; state mental hospital; 5 day, 40 hour week, 3 weeks vacation, 11 holidays; 15 days paid sick leave; must be eligible for Connecticut licensure and have at least 2 years experience in psychiatric nursing. Apply to Director of Nursing, Connecticut State Hospital, Box 351, Middletown, Connecticut.

(Continued on page 208)

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RESIDENT—Junior; California license; co-staff; 50-beds; $7200.00 and maintenance; photo required. Apply B. Caldwell, 2406 S. Hoover, Los Angeles 7, California.

SUPERINTENDENT OF NURSES—Woman with executive experience to manage 50-bed modern hospital in a North Central California city; applicant must have adequate education in hospital field and some years of successful experience in administration; salary commensurate with experience and ability; give experience, training and references with application. Apply MO 102, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Both day and night; good personnel policies. Apply Director of Nursing, Buffalo General Hospital, 100 High Street, Buffalo 8, New York.

SUPERVISOR—Administrative obstetric; 570-bed general hospital, 76-bed department; supervision of birth rooms, post partum and nursery; salary $3936-$4920; degree preferred; collegiate school of nursing, N.L.N. temporary accreditation; 40-hour week, 9 holidays, 15 day accumulative sick leave, 12 working day vacation, annual increments, social security and retirement; living accommodations available. Apply Miss Louree Pottinger, Medical College of Virginia, Richmond, Virginia.

SUPERVISOR — Obstetric; modern 115-bed hospital; administrative responsibility for 23 beds and 29 bassinets; approximately 1000 deliveries yearly; graduate staff; advance preparation and experience required. Write Director of Nursing, Mount Sinai Hospital, Hartford, Connecticut.

SUPERVISOR—Obstetric; capable taking complete charge department covering three floors of modern air-conditioned building; salary depending on ability, experience, advanced training; liberal employee benefits. Apply, Personnel Office, Southern Baptist Hospital, New Orleans, La.

SUPERVISOR—Obstetrics; responsible for supervision of small unit and teaching program in obstetrics; California registration, academic degree and successful experience in obstetrics required; salary $365; forty-hour week, paid vacation and sick leave and Blue Cross hospitalization provided. Apply Director of Nursing, French Hospital, San Francisco, California.

SUPERVISOR — Obstetrical; responsible for student teaching and supervision; no administrative duties; 550-bed hospital; 250 students; starting salary is $4200 for a degree and no teaching experience, $4800 for experience; 30 days vacation; six paid holidays; 40 hour week; retirement plan in addition to social security; other liberal personnel policies; living conditions attractive; private bath; city has many cultural advantages; hospital situated in beautiful 40 acre park. Apply Director of Nurses, Reading Hospital, Reading, Pa.

SUPERVISOR—Operating room; 54-bed general hospital, experience desirable, liberal personnel policies; salary commensurate with preparation and experience; increase in salary every 6 months for a period of 2 years. Contact Esther M. Squire, R.N., Administrator, Washington County Hospital, Washington, Iowa.

SUPERVISOR—Operating room and assistant operating room supervisor; JCAH fully approved 130-bed hospital; 40-hour week; salary commensurate with preparation and experience. Apply Administrator, St. Joseph's Hospital, Minot, North Dakota.

SUPERVISOR—Pediatric; responsible for student teaching and supervision; no administrative duties; 550-bed hospital; 250 students; starting salary is $4200 for a degree and no teaching experience, $4800 for experience, 30 days vacation; six paid holidays; 40 hour week; retirement plan in addition to social security; other liberal personnel policies; living conditions attractive; private bath; city has many cultural advantages; hospital situated in beautiful 40 acre park. Apply Director of Nurses, Reading Hospital, Reading, Pa.

PURCHASING AGENT—220-bed hospital; located large city, Pacific northwest; male, married; age 30-45; minimum 5 years hospital purchasing and storeroom experience; college education preferred; state salary expected. Apply MO 98, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

(Continued on page 210)

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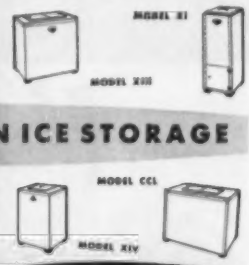
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HCP helps free dirt and grime from floors almost instantly.



HCP helps hold dirt and grime in liquid suspension for easy removal.



HCP is completely safe for all types of floors.

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Super Safety Cleaner, with HCP added, gets rid of floor dirt *fast.* But not at the risk of floor damage. **Super Safety Cleaner is *safe.*** Field tests have proved it is harmless to asphalt tile, rubber tile, linoleum, terrazzo, concrete, wood, magnesite and all other types of floors. **Super Safety Cleaner is *economical.*** Because of its high concentration, it goes more than twice as far as ordinary cleaners. Just 1½ ounces added to a gallon of water, even hard or cold water, will do almost all cleaning jobs *fast.* For fast removal of heavier wax build-ups, 8 ounces of Cleaner per gallon of water is recommended.

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POSITIONS OPEN

SUPERVISOR—Surgical; 250-bed voluntary general hospital, not tax supported; seven new air conditioned operating rooms in new wing; excellent working conditions, progressive community; salary open. Apply Decatur and Macon County Hospital, Decatur, Illinois.

TECHNICIAN—Registered laboratory; single, white female; needed immediately; salary $250.00 per month with full maintenance. Apply Medical Director, Florida State Hospital, Arcadia, Florida.

TECHNICIAN—Registered laboratory; for 265-bed teaching hospital, located on Chicago's near-north side; modern laboratory; starting salary $290 month; alternate 5 and 6 day week; merit increases; excellent employee benefits including 4 weeks vacation; 12 days sick leave; laundry furnished and a 50% tuition reduction on courses at Northwestern University. Apply Passavant Memorial Hospital, 303 East Superior Street, Chicago 11, Illinois.

TECHNICIANS—Laboratory; two; for 186-bed hospital; full-time pathologist; approved for training of residents in clinical pathology and pathologic anatomy; approved training school for technicians; approximately 80,000 tests per year; salary open to discussion. Apply Pathologist, Beverly Hospital, Beverly, Massachusetts.

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ADMINISTRATORS—(a) Director, general hospital, 400-beds affiliated university medical school; $10-$20,000 depending upon training, experience, whether medical or non-medical. (b) General hospital, 400-beds, affiliated medical school; construction recently commenced; outstanding opportunity. (c) Medical administrator; 1000-bed hospital; foreign. (d) Assistant medical; new 500-bed teaching hospital; northwest. (e) Voluntary general hospital, 225-beds, currently under construction; residential town near large city, university medical center, midwest. (f) Small general hospital; expansion program; California. (g) Assistant, 500-bed general hospital, teaching institution; large city, medical center, east. (h) Hospital consultants; Master's degree, experience required; foreign. MH5-1

ADMINISTRATORS—WOMEN; (a) Assistant administrator; voluntary general hospital, 350-beds; large city, medical center; Master's required. (b) Small general hospital; residential town near university center, midwest; $6000. MH5-2

(Continued on page 212)

MEDICAL BUREAU—*Continued*

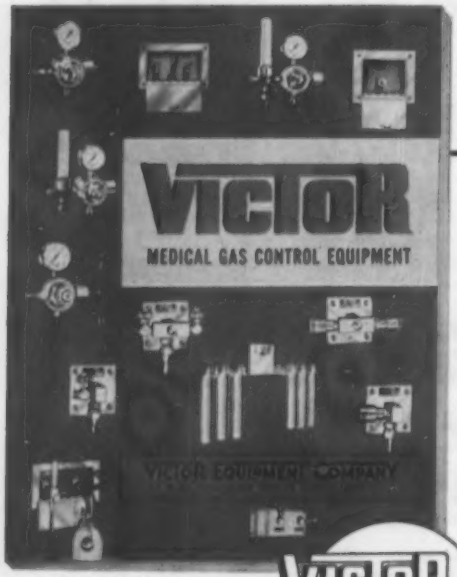
ANESTHETISTS—(a) Two; general hospital, 150-beds; resort town on one of the Great Lakes, short distances, two university cities; $500-$650. (b) Small general hospital, one of smaller Islands Hawaiian group; minimum $400. (c) General hospital, 350-beds; residential town near New York City; medical anesthesiologist in charge. (d) Small general hospital; resort town, Pacific Northwest; minimum $550. (e) New 100-bed hospital; resort town, Northern California. MH5-3

CLINIC, COLLEGE, SOCIAL DIRECTOR—(a) Infirmary supervisor; woman's liberal arts college; staff of four physicians, six nurses; east. (b) Head, nursing department, 20-man clinic; midwest. (c) Social director, new 350-bed hospital and affiliated clinic, 26 Board men; duties include counseling; east. (d) Student health; liberal arts college, September, '55; South. MH5-4

DIETITIANS—(a) Chief dietitian—voluntary general hospital, 250-beds; town 75,000 near university center, midwest; $5000-$7000. (b) Three assistant dietitians; one should be qualified to serve as therapeutic dietitian; new 300-bed general hospital; California. (c) Chief; 350-bed teaching hospital; staff of six assistants; $6500; university city, east. (d) Therapeutic dietitian; 200-bed hospital; college town, south, $6000. (e) Chief, voluntary general hospital, 400-beds; new dietary department, well staffed; $5000; California. MH5-5

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Here's the first elastic bandage you can put in the dryer—along with sheets and towels.

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Heat as high as 280° won't hurt it. Even in the autoclave Tensor keeps its stretch. Tensor lasts longer. Costs less to use. No wonder hospitals favor an elastic bandage made with *heat-resistant* live rubber threads. Shouldn't *your* hospital use Tensor, too? Contact your Curity man today!

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

DIRECTORS OF NURSING—(a) Dean, college of nursing to be established at university in connection with its new college of medicine; preferably one experienced in establishing new programs with distinct interest in new approaches to nursing education. (b) General 400-bed hospital, all departments well staffed; interesting city outside Continental United States; mild pleasant climate. (c) General 500-bed teaching hospital; 150 students; university medical center, south. (d) Small general hospital, school averages 22 students; Turkey. (e) New 300-bed teaching hospital now being completed on university campus; medical center, midwest. (f) Assistant director, school of nursing; modern general hospital, 275-beds; 40 students; new, completely equipped educational unit; college town, New England. (g) Nursing service; 275-bed hospital; woman of extremely high caliber required; large city, midwest; $10,000. (h) Nursing service; one of country's leading teaching institutions; collegiate school is under direction of dean of nursing. MH5-6

EXECUTIVE HOUSEKEEPERS—(a) General 450-bed hospital, unit, university group; large city, medical center, east; substantial salary. (b) General, 225-bed hospital currently under construction, completion in October, university city, south. MH5-7

MEDICAL BUREAU—*Continued*

EXECUTIVE PERSONNEL—(a) Comptroller; supervisory experience in hospital accounting required; voluntary general hospital, 700-beds; east. (b) Food supervisory; 250-bed general hospital; $7000; midwest. (c) Director of maintenance; new 225-bed general hospital currently under construction; university town, south. MH5-8

FACULTY POSTS—(a) Dean, program for graduate nurses only; preferably one with doctoral degree. (b) Assistant professors in obstetrics, psychiatry, public health; department of nursing, liberal arts college; east. (c) Instructor-administrator; 70-bed obstetrical hospital; unit, university group, duties: directing hospital, teaching obstetrics; university city, Pacific Coast. (d) Pediatric, obstetrical and nursing arts instructors; general 400-bed hospital; attractive city outside United States. (e) Educational director; general hospital; New England; $5500-$6600. (f) Clinical instructors in orthopedics, operating room technique and nursing arts instructor; teaching hospital, 400-beds; university town; opportunity continuing studies. MH5-9

MEDICAL RECORD LIBRARIANS—(a) Chief; voluntary general hospital, considered one of the leading in California; $400. (b) To take complete charge of record departments, 300-bed general hospital; should be qualified

MEDICAL BUREAU—*Continued*

to supervise staff of seven; university town, Pacific Northwest. (c) Chief; qualified to re-organize department, 400-bed hospital; unit, university group; expansion program; medical center, east; attractive proposition. (d) Two assistants; 400-bed general hospital, air-conditioned; university and resort city, southwest. MH5-10

STAFF AND SURGICAL—(a) Large general hospital, vicinity New York City; $3170-$4050. (b) Surgical; small general hospital; resort town near San Francisco. (c) Staff and surgical; new hospital, Chicago area. (d) Two; staff; Hawaii. (e) Staff and surgical; Alaska. MH5-11

SUPERVISORS—(a) Operating room; 375-bed general hospital; town, 80,000, near New York City, short distances, 2 universities; $400, maintenance. (b) Central service and floor; new hospital opening in June; Chicago area. (c) Chief admitting officer; 300-bed general hospital; university city, New York. (d) Operating room, obstetrical, pediatric and psychiatric; beautiful modern hospital; expansion program recently completed; resort city, south. (e) Obstetrical; new hospital 100-beds; coastal town, Pacific Northwest. (f) Operating room; new air conditioned department; 300 operations monthly; children's hospital; outstanding staff; medical center; minimum $5000. MH5-12

(Continued on page 214)

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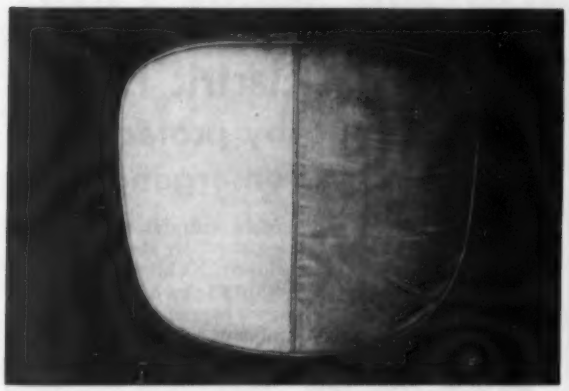
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1. A complete vinyl-coated surface that b-r-e-a-t-h-e-s for greater sitting comfort. Dramatic smoke test shows why "Fabrilite"—in stunning new Russel Wright-designed Castleton pattern—gives you the *full* benefit of foam-rubber construction . . . makes cushions reversible without vents. Try this test, see how Castleton breathes through thousands of invisible pores. It's durable, cleans in a jiffy—has all the exclusive "Fabrilite" advantages *plus* breathability.



2. A dry high-slip finish that means greater sitting comfort. Here's a test that dramatically demonstrates the comfort of "Fabrilite." Two equal weights are placed on inclined surfaces that have been covered with "Fabrilite" (left) and ordinary vinyl upholstery (right). See how much farther the weight slides on the high-slip finish of "Fabrilite"! This pleasant dry "feel" of "Fabrilite" makes an important contribution to the comfort of patients and visitors.



3. A dry, soil-resistant surface that stays clean longer . . . is easier to clean. Here's more proof "Fabrilite" gives customers more for their money. Unretouched photo of cushion used continuously for over two months *without washing* shows how much better "Fabrilite" (left half of cushion) resists soiling than ordinary vinyl upholstery (right). The dry surface of "Fabrilite" simply does not collect as much dirt . . . cleans with the whisk of a damp sponge.



4. Snap-back shape retention that ends sagging and wrinkling problems. Be sure your furniture *keeps* its showroom look. These unretouched photographs of chairs exposed to hard service for two years under identical conditions show how "Fabrilite" (on left chair) keeps its unwrinkled appearance longer than ordinary upholstery (right). Elastic-supported "Fabrilite" has both "suppleness" for comfort, and resilience to snap back to its original shape.

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BETTER THINGS FOR BETTER LIVING
. . . THROUGH CHEMISTRY

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elastic-supported vinyl upholstery

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POSITIONS OPEN



ADMINISTRATORS — (a) Medical; teaching and research hospital, 425 beds; to $20,000; large city. (b) Lay or medical; hospital affiliated, Mayo Foundation and important medical school. (c) Lay; hospital 400-beds, teaching unit important medical school; about $20,000; large city. (d) Medical; assistantship; 450-bed hospital, medical school affiliated; large city; south-central. (e) Lay; general hospital 650-beds; medical school affiliated; west. (f) Medical; voluntary general hospital, large size; affiliated important medical school; east. (g) Lay; new general hospital 125-beds; planning expansion working toward approval; prefer mature person with at least 2 years experience; attractive county seat town; central. (h) Lay; assistant; new post; 700-bed general hospital, medical school affiliated; opportunity succeed present administrator few years; large city. (i) Medical; 175-bed voluntary general hospital; large town, east-coast. (j) Medical; general

WOODWARD—*Continued*

hospital 250-beds; $12-$15,000; west-coast. (k) Lay; assistant; with several years experience and M.H.A.; general voluntary hospital, approved JCAH, 300-beds; expansion program, city 350,000, midwest. (l) Lay or RN; new 100-bed convalescent hospital; large city; midwest. (m) Lay; new general hospital, 150-beds; college town; south. (o) Lay; general hospital 100-beds; staffed by Diplomates on faculty medical school; midwest.

ADMINISTRATIVE EXECUTIVE POSTS—(a) Accountant; 300-bed general hospital; Canada. (b) Accountant; voluntary general hospital, 285-beds; minimum $6000, good sized college town; midwest. (c) Business manager; 90-bed general hospital; attractive town; west-mountain. (d) Business manager; small general hospital; to $6000; Great Lakes city; university medical center. (e) Business manager; voluntary general hospital, 250-beds; medical school affiliated; about $6500; university city; south. (f) Comptroller; with supervisory experience in hospital accounting field; 800-bed teaching hospital; east. (g) Comptroller; new 200-bed hospital; town 85,000; southeast. (h) Comptroller; 275-bed, voluntary general hospital; college town, large trade drawing area; central. (i) Credit manager; voluntary general hospital, 300-beds; college town 100,000; midwest. (j) Personnel director; duties will include editing hospital publications; 400-bed voluntary general hospital; medical center; midwest. (k) Purchasing director; 300-bed voluntary general hospital; college town, 100,000; midwest.

(Continued on page 216)

WOODWARD—*Continued*

ADMINISTRATORS—Women: (a) Lay or R.N.; experienced in opening new hospital; 150-bed hospital; about $7200; south. (b) R.N.; small general hospital; salary and full maintenance; agricultural area; midwest. (c) Lay or R.N.; must speak and write Spanish; 150-bed industrial hospital; attractive foreign location. (d) Lay or R.N.; 100-bed general hospital, 2 years old; west-central. (e) Lay or R.N.; 40-bed general hospital now under construction; attractive town; midwest.

ANESTHETISTS—(a) Prefer to also do other nursing; 3 man clinic group and 25-bed general hospital; to $600 or percentage arrangement; southwest. (b) Also serve as superintendent of nurses; 50-bed general hospital; to $600; attractive small town; south. (c) Voluntary general hospital 70-beds; approximately 1000 surgical proc. per year; lovely resort town; New England. (d) 4 required; active surgical service; approved 200-bed general hospital; $6-$7000; town 35,000 near university medical center; mideast. (e) Sev.; new 100-bed general hospital; town 30,000; southwest. (f) General hospital 100-beds; $550; Pacific Northwest. (g) 4-man clinic group; resort and industrial town 40,000; south-central.

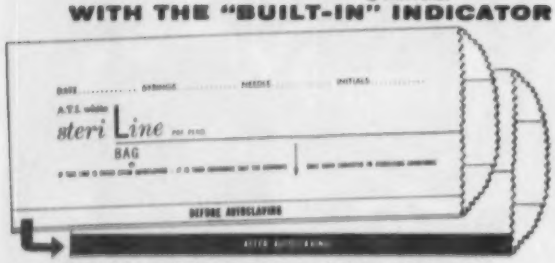
DIETITIANS—(a) Chief; 200-bed voluntary general hospital; to $7000; town 50,000; middle east. (b) Therapeutic fully approved 300-bed general hospital; $375 start; large city near university medical center; midwest. (c) Chief; new medium sized general hospital; attractive town 15,000; California. (d) Administrative; new department now being set up with central food service; 150-bed general hospital; attractive town 40,000; midwest. (e) Chief; 225-bed hospital; new and ultra modern; lovely resort city; Florida.

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WOODWARD—*Continued*

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EXECUTIVE HOUSEKEEPERS—(a) 300-bed pediatric and maternity hospital; university affiliated; large university city; east. (b) Large university hospital; Pacific northwest. (c) Voluntary general hospital 150-beds; residential suburb university medical center; east. (d) Male; fully approved 300-bed hospital; resort and university city; midwest. (e) Superintend approximately 18 employes; 110-bed general hospital; residential suburb university medical center; east.

FACULTY POSTS—(a) Educational director; school temporary NLNE accredited; fully approved 300-bed general hospital; to $4800; city 100,000; midwest. (b) Educational director; potential 200 students; large teaching hospital; to $6600; east. (c) Assistant nursing arts instructor; 600-bed university hospital; large city; south. (d) Science instructor; class of 40 admitted per year; 500-bed general hospital; vicinity New York City.

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DIRECTORS, Nursing Service—$4500-$6000.

(Continued on page 218)

INTERSTATE—*Continued*

DIRECTOR, SCHOOL OF NURSING—(a) 300-bed hospital, mid-west. (b) 300-bed hospital, Ohio. (c) 185-bed hospital, Maryland; $400, maintenance.

DIETITIAN—(a) Administrative; 300-bed hospital, central state; $5500-$7000. (b) Therapeutic; to $350.

EXECUTIVE HOUSEKEEPER—(a) 200-bed hospital, Michigan. (b) 300-bed new hospital, midwest. (c) 250-bed New Jersey hospital. (d) 225-bed hospital, Ohio.

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PHARMACIST—250-bed hospital, Ohio. Open.

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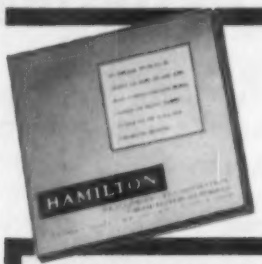
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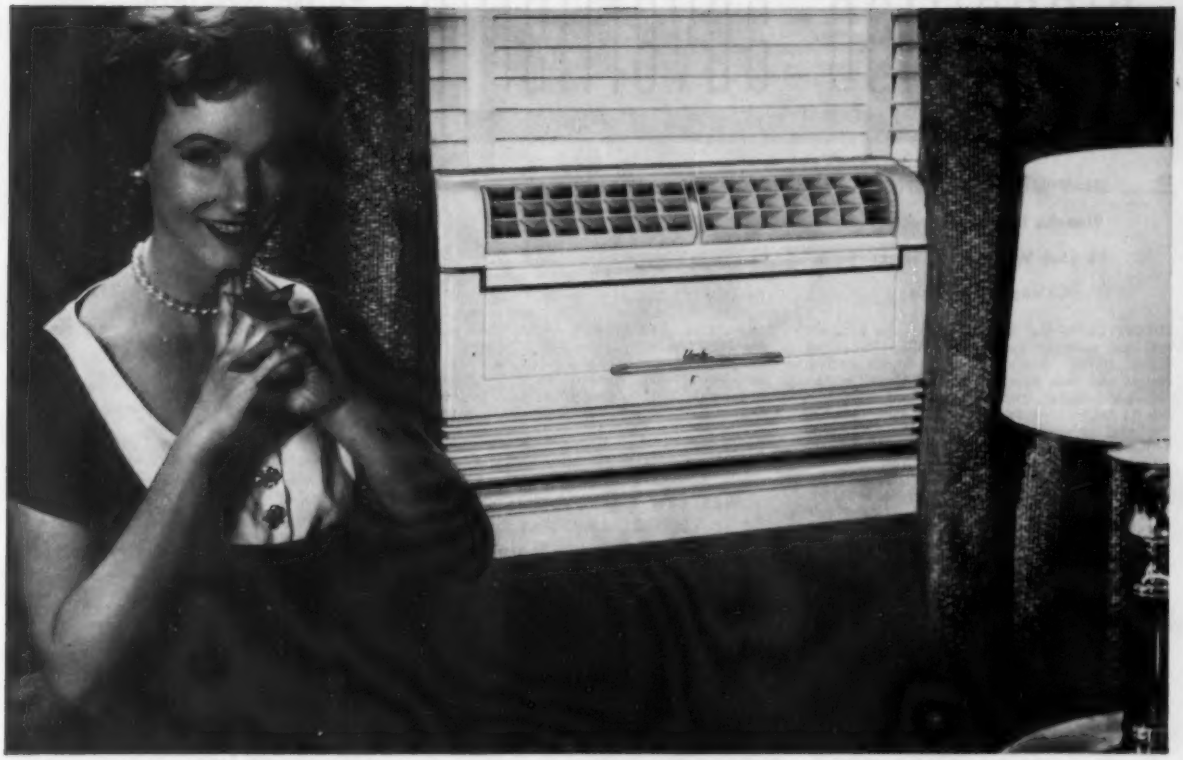
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EXECUTIVE HOUSEKEEPERS—(a) South; 300-bed hospital; 2 assistant housekeepers and 53 employees in department. (b) East; 225-bed hospital; 60 employees in department; located in city of 25,000 easily accessible to New York and Boston. (c) Middle west; 200-bed hospital in pleasant college town; experience in interior decorating would be helpful. (d) Pacific Northwest; 350-bed general hospital; 50 employees in department. (e) 400-bed hospital; medical

SHAY—*Continued*

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(Continued on page 220)

WESTERN EMPLOYMENT—*Continued*

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(Continued on page 222)

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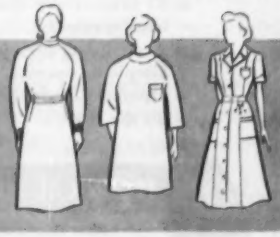
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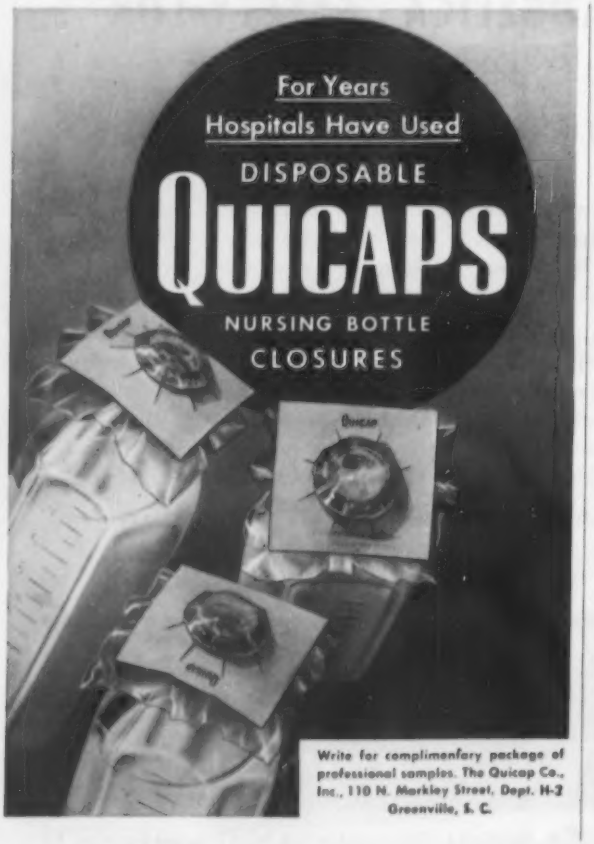
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CHF

Exclusive NEW Designs!

New "Flare" design table is just one of many distinctive styles exclusive with "CHF." Widest selection helps your designer pick the style exactly right for your installation.

Widest Range of Colors and Finishes!

Only at "CHF" will you find solid bronze...chrome...anodized aluminum...porcelain enamel in 16 colors...or upholstery in so many choices. *Plus* lifetime cast construction.

11 WINNERS in N. F. S. Contest Prove Distinctive Quality of "CHF" Installations!

You owe it to yourself to see the complete "CHF" line. Compare the quality. Learn why, year after year, CHF Stools and Tables are represented in the top award winners in the National Food Service Contest, plus thousands of other distinctive installations all over the country. In addition to better design and widest color selection, "CHF" gives you *cast construction* for a lifetime of dependable service.

Write Today For Color Catalogs!

Complete listing of stools and tables in color, plus many installations photos.

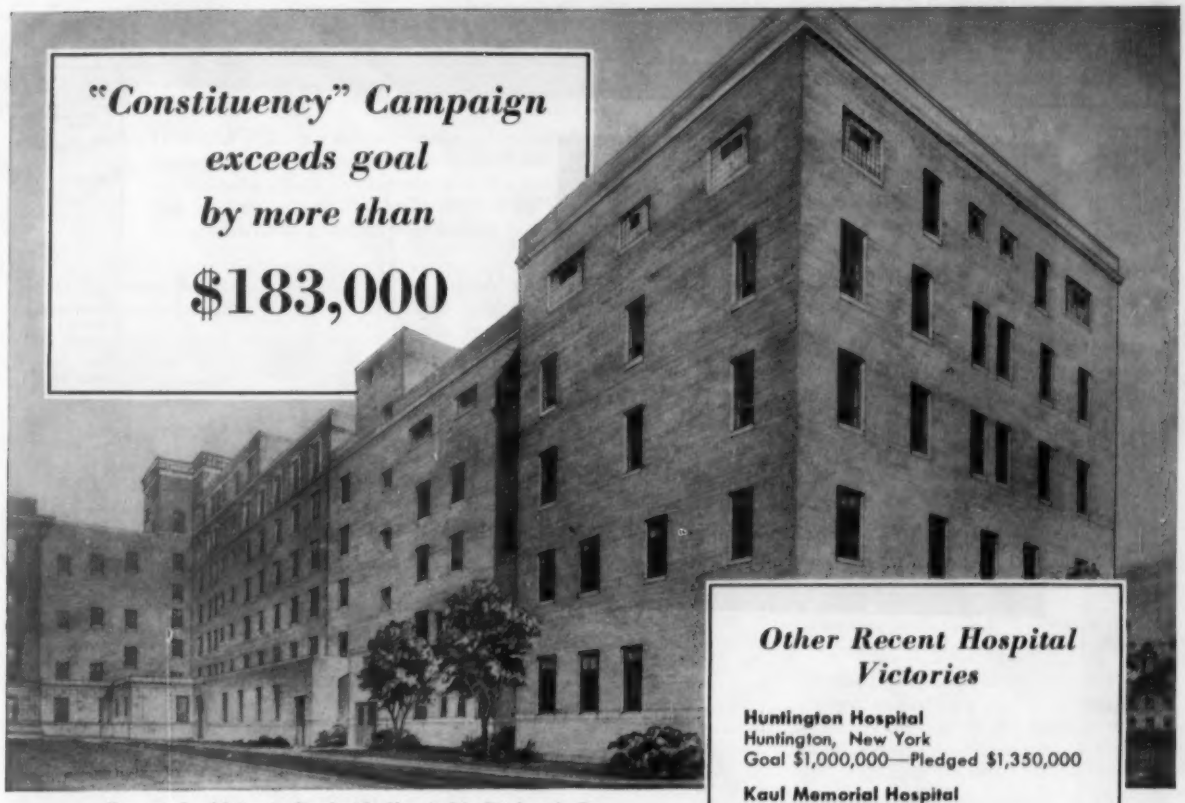


DISTRIBUTORS IN ALL PRINCIPAL CITIES

The Chicago Hardware Foundry Company

"Dependable Since 1897"

4155 Commonwealth Ave.
NORTH CHICAGO, ILL.



Proposed addition to Shadyside Hospital in Pittsburgh, Pa.
Administrator: William E. Barron
Architects: Press C. and William C. Dowler, A.I.A.

SHADYSIDE HOSPITAL, Pittsburgh, Pa.

Goal: $1,150,000

Pledged: $1,333,687

That prize-winning combination of excellent volunteer leadership and top professional direction proved its worth again when the recent building fund campaign at Shadyside Hospital in Pittsburgh went over the top. Already exceeding its goal by more than $183,000, additional pledges are expected to bring the final total to $1,400,000!

This has been the third Ketchum-directed campaign at Shadyside. The others were conducted in 1924 and 1939. It succeeded despite an unprecedented number of fund campaigns being conducted at the same time in Pittsburgh—including large-objective appeals for the Medical Center of the University of Pittsburgh and many other hospitals.

The secret of success in this case was a "constituency" appeal—a campaign directed only at those who had a special interest in Shadyside.

Ketchum, Inc. invites your inquiries—without obligation.

Other Recent Hospital Victories

Huntington Hospital
Huntington, New York
Goal $1,000,000—Pledged $1,350,000

Kaul Memorial Hospital
St. Marys, Pennsylvania
Goal $800,000—Pledged $899,000

Borgess Hospital
Kalamazoo, Michigan
Goal $1,500,000—Pledged $1,649,000

Children's Hospital
Akron, Ohio
Goal $2,309,000—Pledged $2,600,000

St. Joseph's Hospital
Stamford, Connecticut
Goal $1,000,000—Pledged $1,401,000

East Liverpool City Hospital
East Liverpool, Ohio
Goal $750,000—Pledged $1,037,000

Ohio Valley General Hospital
Wheeling, West Virginia
Goal $1,500,000—Pledged $1,915,000

Conemaugh Valley Memorial Hospital
Johnstown, Pennsylvania
Goal $1,300,000—Pledged $1,875,000

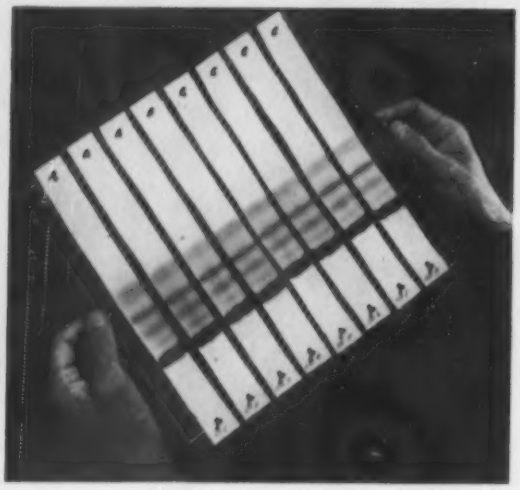
Southside Hospital
Bay Shore, Long Island, New York
Goal $900,000—Pledged $1,009,000

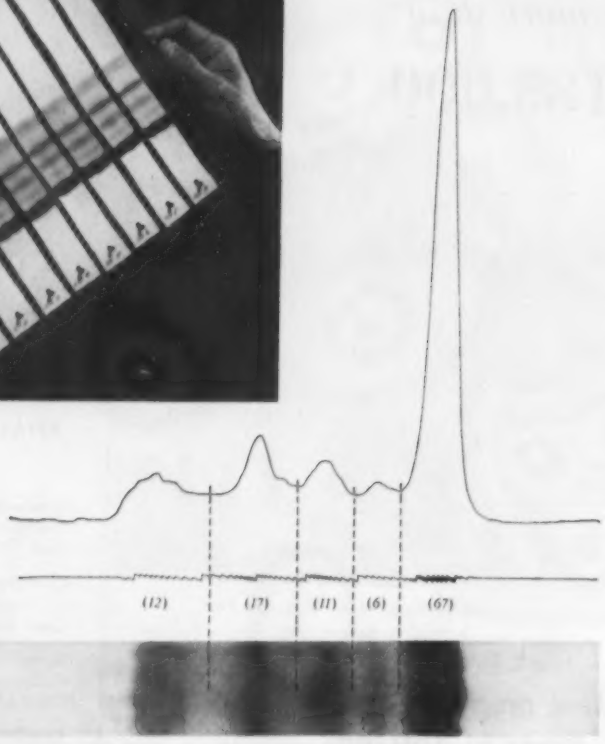
KETCHUM, INC.

Campaign Direction

CHAMBER OF COMMERCE BUILDING, PITTSBURGH 19, PA. AND 500 FIFTH AVENUE, NEW YORK 36, N.Y.
CARLTON G. KETCHUM, *President* • NORMAN MAC LEOD, *Executive Vice President*
MC CLEAN WORK, *Vice President* • H. L. GILES, *Eastern Manager*

Member American Association of Fund-Raising Counsel





RESULTS • *reproducible - rapid* • *automatically recorded*

NEW SPINCO Model R PAPER ELECTROPHORESIS

For the first time, a complete paper electrophoresis system with coordinated features for simple routine analyses in the clinical laboratory. Every step is systematized from precision application of the specimen to final automatic recording of the relative concentrations. Ask for full details.

BECKMAN

Spinco *division*

BECKMAN INSTRUMENTS, INC.
BELMONT 2, CALIFORNIA

Equipment and Supplies Stocked by Distributors in Principal Cities throughout U. S. and Canada

WHAT'S NEW FOR HOSPITALS

MAY 1955 Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 256. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it

Blood Pressure Device Records Automatically



A constant check on a patient's blood pressure can be made with the new electronic automatic blood pressure recorder. It automatically records pressure at selected intervals of from 30 seconds to one hour, measuring both diastolic and systolic pressures. Any pressure may be set into the device and if the pressure falls to that level, a signal system will call the nurse of a post-surgery or cardiac patient. The machine is connected to a buzzer, bell or light system as preferred.

The device is operated by a microphone strapped over the blood pressure cuff at the point where the stethoscope is ordinarily applied. Sound impulses are amplified by an electrical circuit which actuates a printing device. **The Colson Corporation, Elyria, Ohio.**

For more details circle #791 on mailing card.

Automatic Machines for Flake-Ice Production

A new line of ice making machines has been developed by Carrier Corporation for every need. Two new large-capacity automatic ice-making machines recently introduced are designed to produce one to two thousand pounds of flake-ice a day. A chip-ice machine with a capacity of 500 pounds a day is also available. The Flakemasters are available with standard storage bins of 500 pounds capacity with either two or three access doors. They range between six and eight feet in height when mounted on standard bins and are produced in a range of standard voltages for easy installation. The Chipmasters have bins of 250 pounds capacity but custom-made bins may be had for greater storage needs.

The new machines are added to the Carrier Icemaker line producing cubed or crushed ice. Individual machines located in floor kitchens and utility rooms make supplies of flaked or chipped ice readily available at place of need. **Carrier Corporation, Syracuse, N.Y.**

For more details circle #792 on mailing card.

Cubicle Curtains of Mersan Poplin

More tightly woven than fine percale sheets, Mersan Cubicle Curtains are mercerized for extra durability and Sanforized for resistance to shrinking. They have a fine, soft finish with an attractive appearance and yet stand up under repeated laundering. Maintenance costs are reduced and the price is economical. The new Mersan Curtains are available in white, Eden Blue, gray, Paget Pink,



emerald green, tan, maize, pistachio, coral and orange ice. All colors are lightfast and washfast. **Webb Manufacturing Co., 2936 N. Fourth St., Philadelphia 33, Pa.**

For more details circle #793 on mailing card.

Luminous Plastic for Lighting Fixtures

Luminous plastic is used in concentric rings in a new line of fixtures for incandescent lighting. The one-piece, pressure molded plastic louvers give very low brightness ratio with effective lighting. The vertical planes reduce maintenance since they minimize the accumulation of dust and dirt. The gently glowing acrylic plastic rings provide decorative luminosity. The units are available for pendant or ceiling mounting in wattages from 150 to 500. **Kurt Versen Company, Englewood, N.J.**

For more details circle #794 on mailing card.

(Continued on page 228)

High-Gloss Floor Wax Is Non-Slip

Floors dry to a hard lustrous mirror-like sheen without buffing or polishing when waxed with Super Westwax. This new water-based floor wax is listed by Underwriters' Laboratories as an anti-slip floor maintenance product, making it especially suitable for use in hospitals and other institutions. Super Westwax has unusual wear resistance and a single application usually is adequate for normal floor protection. **West Disinfecting Co., 42-16 West St., Long Island City 1, N.Y.**

For more details circle #795 on mailing card.

Dry Copying Machine Operates Rapidly

Speedy copying of any printed, written or drawn original material is possible with the new Secretary brand copying machine. Small enough to be used on an office desk, the machine makes accurate dry copies of originals in about four seconds, transparent or opaque, printed on one or both sides, regardless of the color of paper on which the original is printed.

The machine operates from any light outlet, employing a special light in the machine and a special copying paper. No liquids, negatives or master copies are involved and copying is direct, from the original to the copy, regardless of lighting conditions. The machine is



easily operated with a few minutes of instruction and copies are made at low cost. **Minnesota Mining and Mfg. Co., 900 Fauquier St., St. Paul 6, Minn.**

For more details circle #796 on mailing card.

WHAT'S NEW

Nightingale Stand Is Redesigned

Combining an overbed and bedside table in one unit, the redesigned Tomac Nightingale is a compact and efficient cabinet. It is convenient and attractive



and saves floor space at the patient's bedside. The storage cabinet has ample space for storing necessary utensils and supplies for the patient and there is room for books, radio or other personal items. An optional table top shelf is easily affixed if desired. The adjustable utility tray can be used as a bookrest and has a mirror. There is a chrome plated towel bar on both sides.

The unit is of all steel construction with Formica top on the overbed table in gray or tan finish. The table can be adjusted at any point between 30 and 45 inches high and the unit is easily moved on 3 inch ball-bearing casters by nurse or patient. **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #797 on mailing card.

"Designs of Tomorrow" in Ambulance Bodies

Three different styles are offered in the new Meteor ambulances: the Conventional, Landau Panoramic and Landau Traditional. Designed on Cadillac chassis, the ambulances offer a long list of features for maximum convenience, safety and efficiency.

The new Salon Interiors have fluted paneling, chrome plated accents and a choice of attractive color combinations. The Continental silhouettes present low sweeping lines with full length fender treatment and complete alignment of all glass areas. The wide rear door with extra head clearance and low loading height facilitate loading and unloading of patients. The dynamically balanced doors have positive hold-open checks and built-in side-door safety locks. A dispensary cabinet and blanket and linen compartment with concealed bedpan compartment make for efficient patient care in transit. Storage space for the foldaway cot or collapsible stretcher and for tools is under the floor. **Meteor Motor Car Company, Piqua, Ohio.**

For more details circle #798 on mailing card.

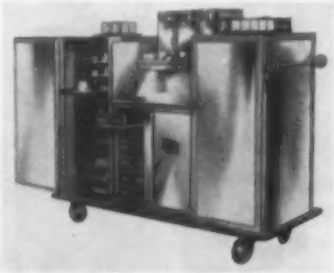
Floor Cleaning Machine Combines Speed With Power

Speed and power are combined in the new Lincoln Jet, making it especially suitable for all types of institutional cleaning. Simultaneous wet and dry pick-up without changing internal parts is possible with this all-purpose vacuum cleaner. Other features of the Jet include extra large filter bag, easy-open lid clamps, rust resistant twelve or fifty gallon capacity tank, easy-rolling, self-lubricating rubber casters and self-lubricating continuous duty by-pass motor. **Lincoln-Schlueter Floor Machinery Co., 1250 W. Van Buren St., Chicago 7.**

For more details circle #799 on mailing card.

Mobil-Meal System for Efficient Food Service

A complete mobile food system using airline methods to deliver hot and cold foods to the patient is introduced in the Mapco Mobil-Meal System. The system is designed to serve as many as 24 patients in a group in less than one minute per serving, producing hot foods hot and cold foods cold. Food can be prepared well in advance of serving, loaded into



the Mobil-Meal conveyor, and taken to the floor or wing. Food will stay warm for hours, even after the current is disconnected.

The Mapco Mobil-Meal conveyor has two removable hot food ovens with a choice of high or low settings for the heating compartment. Three hot liquid containers are electrically heated and thermostatically controlled. The containers may also be used to dispense refrigerated liquids by utilizing the dry ice well built into the cover. Two refrigerated tray compartments holding 24 trays will accommodate completely set up trays up to 16 by 22 inches in size.

The stainless steel clad conveyor, with service for 24 patients, has an all welded aluminum extruded frame for maximum rigidity with minimum weight. It has ample area for tray assembly, a full width push handle, 6 inch ball bearing rubber tired wheels for easy mobility, and a heavy rubber bumper. Ovens and liquid containers are removable for easy cleaning and the system saves labor and floor space. **Mansfield Aircraft Products Co., Municipal Airport, Mansfield, Ohio.**

For more details circle #800 on mailing card.

(Continued on page 232)

Measurement of Bones by Single X-Ray Exposure

The O-W Radio Osteometer is a device designed for the measurement of bones by single x-ray exposure. It gives direct film reading on a grid system that automatically eliminates distortion. The device is easy to attach to x-ray equipment, is inexpensive and simple in application. It is applicable for clinical use in length discrepancies, intra medullary nailing, hip nailings, measurement for hip prosthesis, localization of foreign bodies, including tumors, pelvimetry problems and localization for osteotomy. **Orthopedic Equipment Company, Bourbon, Ind.**

For more details circle #801 on mailing card.

Photocopy Machine Makes Copies Automatically

The new Bantam model Exact-Photo-Copy machine will make 90 copies per hour of anything typed, written, printed or drawn. It copies material up to nine inches in width, in any length, on one or two sides. It is simple to operate and combines all operations in the one light weight portable unit. Finished in gray vinyl for easy cleaning, the interior of the unit is stainless steel. It operates on a regular light outlet. **General Photo Products Co., Inc., Chatham, N.J.**

For more details circle #802 on mailing card.

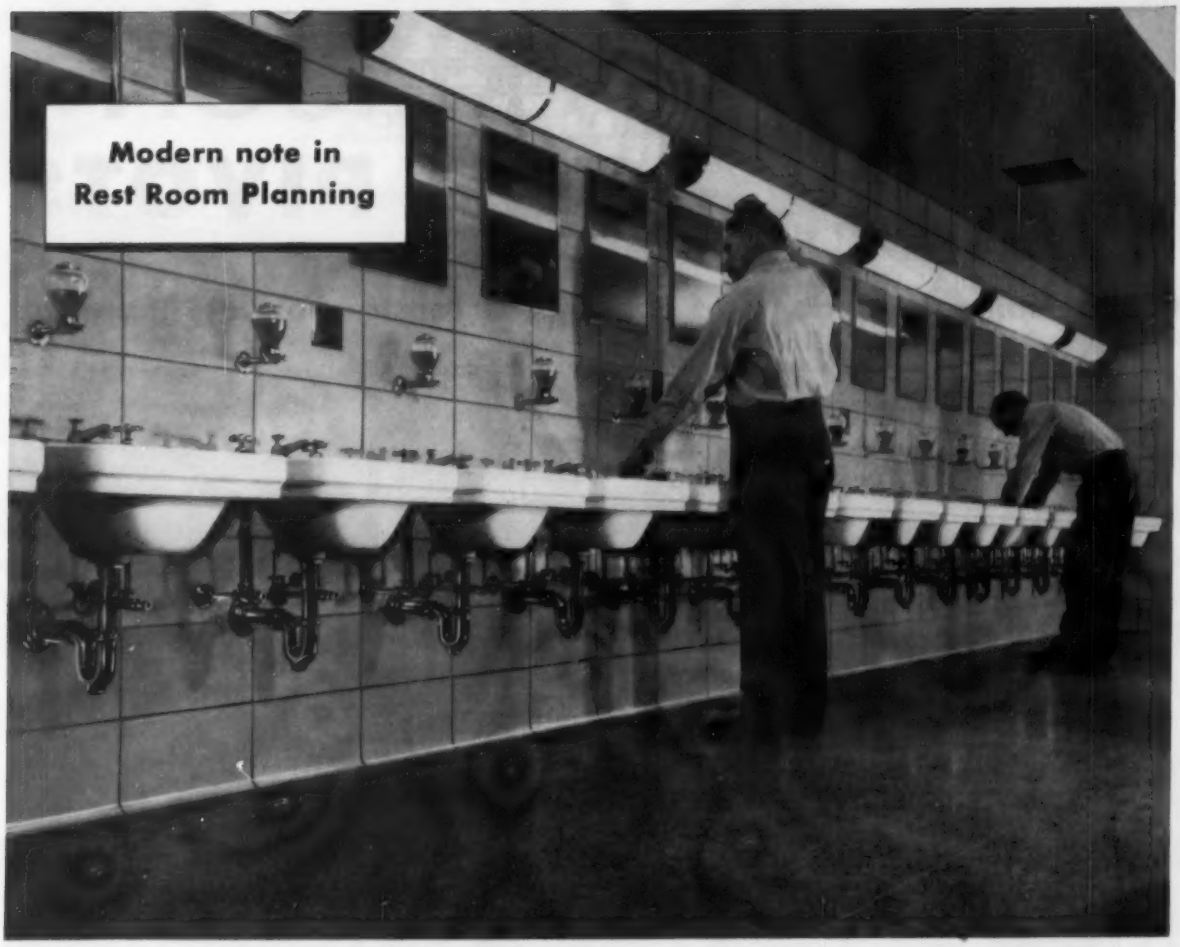
Books Easily Copied With Book-Printer

Copies can be made directly from the pages of any book with the new Cormac Book-Printer. It makes individual photo copies of each page or part of a page from books, documents or pamphlets of any thickness. Anything written, printed, typed, drawn, stamped or photographed can be copied in black and white at small cost. The unit plugs into any



electric outlet and is designed for use with the regular processing units in the Cormac line. The machine is sized for desk top operation and is readily portable. **Cormac Industries, Inc., 80 Fifth Ave., New York 11.**

For more details circle #803 on mailing card.



Simplified **Open Expanse** *design*

contributes to cleanliness . . . builds lasting good will

■ What keeps a rest room like this looking so new and spic and span over the years while other rest rooms become obsolete? Good planning. Planning for *improved sanitation*. Planning for *attractive decor*. Planning for *lowest maintenance*. Planning for *construction economies*.

You achieve all 4 of these desirable points when you use *open expanse* design in your rest rooms. And the key to this is a *fixture-free floor*.

The pleasing effect of uncluttered spaciousness in this rest room was obtained by using American-Standard wall-type plumbing fixtures installed with and supported by Zurn System behind-the-wall carrier fittings. This combination of superbly designed fixtures, and rigid supporting fittings especially engineered to relieve the wall of all the load, gives you an "age-proof" installation that insures against the untimely obsolescence of your rest rooms.

If you would like to know more about the advantages of American-Standard wall-type plumbing fixtures and the Zurn System, we would be pleased to send you two interesting booklets which contain up-to-date information on these essential products. Just ask for the American-Standard "Better Rest Room Guide" and the Zurn booklet, "You Can Build It For Less A New Way."

Plumbing and Heating Division,
American Radiator & Standard Sanitary Corporation, Pittsburgh, Pa.
J. A. Zurn Mfg. Co. (Plumbing Division), Erie, Pennsylvania

AMERICAN-Standard
off-the-floor fixtures
installed with and supported by the
ZURN system®
give you these important benefits—
✓ insured sanitation
✓ simplified maintenance
✓ modern appearance

now 6 RIXSON TOP PIVOTS

to meet all requirements of door–jamb construction and materials



MBB Top Pivot • door and jamb leaves mortised. Modern design for standard construction.

ABB Top Pivot • door and jamb leaves mortised. Asylum design for use in institutions.

No. 580 Top Pivot • door and jamb leaves mortised. For bull nose type metal frame with wood or hollow metal doors.

No. 280 Top Pivot • door leaf surface mounted—jamb leaf mortised. For wood or kalamein doors having wood, kalamein or metal frames.

No. 380 Top Pivot • jamb leaf surface mounted—door leaf mortised. For hollow metal or wood doors having a channel iron frame.

No. 480 Top Pivot • door and jamb leaves surface mounted. For wood, kalamein or tubular steel doors having channel iron frames.

for pivotal hanging of RIXSON offset type floor-installed door closers . . . the most popular and practical.

THE OSCAR C. RIXSON COMPANY

9100 w. belmont ave. • franklin park, illinois

Under the **Toughest** traffic and service conditions...



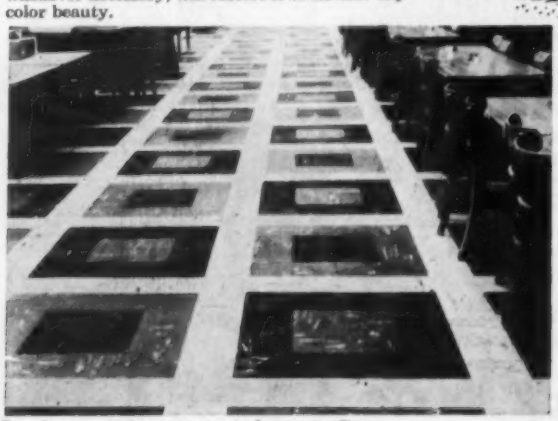
More than a million people use the Miami Terminal of Eastern Air Lines each year. After several years of service, Terraflex has proved its durability . . . looks colorfully new . . . and has cut maintenance time and cost.





Heavy traffic in this Budd Company R.D.C. diesel-powered passenger car has little effect on the durable J-M Terraflex floor. A damp-mopping, whenever necessary, will restore it to its first-day color beauty.





Despite constant exposure to heavy traffic, spilled food, grease, and liquids, the Terraflex floor in the cafeteria of the Sperry Gyroscope Company at Lake Success, L. I. shows no sign of wear—looks as fresh and colorful as the day it was installed.



Johns-Manville TERRAFLEX®

Vinyl-Asbestos Tile Floor

provides beauty, color and wear with minimum care.

IN ADDITION to their inviting appearance, the floors in the busy cafeteria, the railroad car and the major air-passenger terminal, shown here, have one other important common characteristic. Each is a Johns-Manville Terraflex Tile floor . . . selected to meet stringent requirements for heavy-traffic floor service with the lowest possible maintenance cost.

Made of vinyl and asbestos J-M Terraflex is exceptionally tough and resistant to wear . . . defies grease, oil, strong soaps and mild acids.

Terraflex can reduce maintenance costs one half. In actual use, tests showed Terraflex maintenance expense to be approximately 50% less than the next most economically maintained resilient flooring. Its nonporous surface requires no hard scrubbing, damp mopping usually keeps it clean and bright . . . frequent waxing is eliminated. Through years of economical service Terraflex pays for itself.

Available in a range of 15 marbleized colors, J-M Terraflex vinyl-asbestos tile is ideal for restaurants, public areas, schools, hospitals—wherever reliable floor service, long-wearing beauty and long-time economy must be combined.

For complete information about Terraflex vinyl-asbestos floor tile, write Johns-Manville, Box 158, New York 16, N. Y.

See "MEET THE PRESS" Sundays on TV, sponsored by Johns-Manville. Consult your newspaper for time and station.

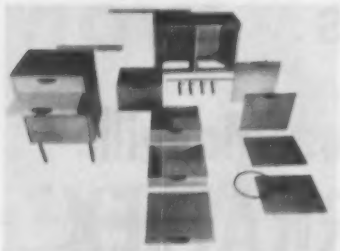
JM PRODUCTS

Johns-Manville

WHAT'S NEW

Basic Furniture Unit Has 72 Combinations

An attractive furniture unit, the Kaleido-Kase, serves as the starting point for



72 different combinations in the Kaleidoscope line of patient room furniture. It is equally effective in nurses' homes and for other residence furniture. The Kaleido-Kase is constructed of select northern hard birch plywood, protected with natural Enduro finish. Legs are of durable, plastic-coated steel and the Formica top protects against cigarettes, acids and stains. Bottom edges are protected by a bump bar.

The modern design and attractive appearance of the Kaleido-Kase make it suitable for many uses. Basic components include a 20 inch case, single drawers, double drawers, pull-out ledges, shelves, swinging doors hinged left or right and back guard. There are 64 double combinations of the eight single units available. The unit combines utility and beauty to meet every storage need in large or small rooms. It offers new flexibility of room arrangement and interchangeability of pieces from room to room. **Carrom Industries, Inc., Ludington, Mich.**

For more details circle #804 on mailing card.

Unit Filing of Microfilms With Microstrip

A new product for converting micro images from roll microfilm to paper cards is offered in Microstrip. Developed especially for the handling of medical records, Microstrip is a full length paper positive copy produced from the users' developed microfilm negative. The back of Microstrip is treated with a plastic



adhesive especially formulated to produce a permanent, flexible bond when moistened with Solox and pressed on a paper card.

A card file of micro images is created by simply cutting Microstrip by subject, moistening the cut strip with Solox and pressing it on an ordinary paper card. A patient's record may thus be kept on one card for quick reference, no matter how many times he may be admitted. Microstrip is low in cost and has a simple method of assembly. **Hall & McChesney Inc., Oswego Blvd., Syracuse, N.Y.**

For more details circle #805 on mailing card.

Rubber Floor Tile Has Tweed-Textured Surface

"Do All Tweed Corded Rubber Tile" is a new non-porous, resilient floor tile. The tweed-textured surface is durable and fade resistant and the tile has high sound absorbing qualities. The new tile may be applied directly to concrete, wood and steel floors using any good rubber tile adhesive. **American Mat Corp., 1719 Adams St., Toledo 2, Ohio.**

For more details circle #806 on mailing card.

Patients Help Themselves With National Grab-Bars

Designed to assist patients who are ambulatory, and to serve as a safety



factor, National Grab-Bars are available in models for many needs. Made of triple plated chromium over rust resistant steel, the Grab-Bars afford sturdy support over tubs, toilets, showers and wherever the patient will find help and confidence by their use.

National Grab-Bars are easily attached to any wall. They are available in four models for tubs, two models for tub and shower, and two models for toilets. **National Steel Products Co., 424 N. Mansfield Ave., Los Angeles 36, Calif.**

For more details circle #807 on mailing card.

Projection Lamps Give Increased Light

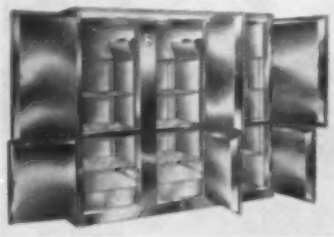
A new filament construction gives 25 to 35 per cent more light on the screen with the improved G-E lamp. Color slides have more brightness with the new 300 watt T-8 ½ bulb with c-13 filament. There is no increase in price in the new lamps. **General Electric Co., Nela Park, Cleveland 12, Ohio.**

For more details circle #808 on mailing card.

(Continued on page 236)

Heavy-Duty Refrigerators of Stainless Steel

The new line of Tyler Reach-In Refrigerators is made of easy-to-clean stain-



less steel. Ranging in capacities from 18 to 79 cubic feet, the heavy-duty line is designed for institutional use in the preservation of perishable foods and pharmaceuticals. The rugged welded-steel construction assures long life and the minimum of three inches of non-settling, super-density insulation assures temperature control and proper sanitation.

Triple-glazed glass doors are standard on the new Reach-In models but solid, stainless steel doors may be specified if desired. Door arrangements are available in a wide variety, including one, two or three doors, sliding or open-out types. All hinged doors have heavy-duty, chrome-plated hardware with positive action latches. **Tyler Refrigeration Corp., Niles, Mich.**

For more details circle #809 on mailing card.

Stair Climbing Is Feature of Hand Truck

Designed especially for use on stairs and ramps, the new Stair Cart is equipped with a special ratchet mechanism which enables it to roll up stairs step by step as the operator pulls a cable drive. Two-wheel safety brakes are incorporated in the truck to prevent accidents when descending ramps or stairs with heavy loads. Sealed ball bearings, steel tube construction and interchangeable shoes are features of the new cart which is designed for load flexibility and long life. It is equipped with large pneumatic tires for ease of operation and to protect



steps from marking. Six models are available for handling loads of various sizes. **Valley Craft Products, Inc., 750 Jefferson Ave., Lake City, Minn.**

For more details circle #810 on mailing card.



Reprinted from the Buffalo, N. Y. Courier-Express

Floral Queen is Crowned

An 18-year-old University of Buffalo nursing student reigned last night over the flower-decked tables of the annual president's dinner of the Florists' Telegraph Delivery Ass'n. Miss Carol E. Rothfuss of 24 Bame Ave. wore her coronet of white carnations with a regal air. Carol was crowned in ceremonies at the close of the dinner in the Connecticut St. Armory's banquet hall. Capt. Basil C. Opalenik, veteran of 100 missions over Korea, crowned the queen to call attention to the Air Force's nurse recruiting program. He told of the debt he owes to Air Force nurses who cared for him when he was wounded in Korea.

Each year the florist's group chooses a student nurse as queen of its convention. In addition to the honors accorded her last night Carol will receive a scholarship enabling her to continue her nursing education at UB.

FLORISTS'
TELEGRAPH
DELIVERY ASS'N
Headquarters: Detroit, Michigan





Put Your Work on Wheels with

LAKESIDE

Stainless Steel CARTS • TRAY TRUCKS • PANS



Utility Carts

Model 311 (left)
15½x24"
shelves..... $29.95

Model 322 (right)
17½x27"
shelves..... $36.50

Heavy Duty Carts

Model 411 (left)
15½x24"
shelves..... $47.00

Model 422 (center)
17½x27"
shelves..... $52.00



Model 526 (right)
17½x27" shelves
2" rim or
guard rail..... $58.00

Sturdy Tray Trucks

Model 433 (left)
Six 21x35"
shelves..... $123.50

Model 355 (right)
Five 18x31"
shelves..... $83.50



**If it's Lakeside
It's Stainless Steel!**



Utility Pans

Model 111
(shown)
21x14½x5"..... $11.00

Model 122
24x16½x5"..... $13.00

*All Prices FOB Milwaukee . . . subject to change.
West Coast prices slightly higher.
See your jobber or write for dealer's name.*

LAKESIDE MFG. INC.
1970 S. Allis St. Milwaukee 7, Wis.

How to LOWER your BLANKET COSTS wisely



ST. MARYS
OFFERS
Sleeping Luxury
AT LOWEST COST
PER YEAR OF
SERVICE RENDERED

St. Marys ®

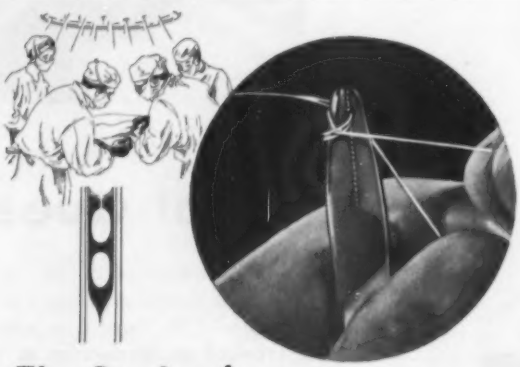
For the better part of a century, St. Marys Blankets have been proving and re-proving their remarkable economy under daily use. Soft, luxurious, beautiful—they add to your reputation for thoughtful service and comfort.

St. Marys Blankets are *certified washable* by the American Institute of Laundering. Available in a variety of sizes and in colors to match or harmonize with your room decor. Regular or special bindings, permanently stamped names or crests.

Write for name of supplier in your territory

ST. MARYS BLANKETS • ST. MARYS, OHIO

"They last . . . and last . . . and last"



The Berbecker "SPRING-EYE" Needle

THE BERBECKER Spring Eye may be threaded at any point on the suture merely by forcing the suture through the slot into place. It is then held as securely as though in a solid eye.

This eye permits use of black silk or other non-absorbable sutures, as used in the Halsted technique, for stomach and other abdominal operations, where tension on the wound is excessive. One of many dependable Berbecker needles obtainable regularly at your surgical supply dealer.

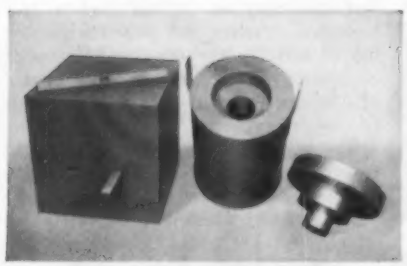
Julius Berbecker & Sons, Inc., 15 E. 26 St., New York 10, N.Y.

BERBECKER SURGEONS' NEEDLES

Made In England for the Surgeons and Hospitals of America



For high density in small volume... For maximum adaptability... Lead



Typical lead shielding items – lead safe (cube), lead cask and extruded curved-joint lead brick.



Lead shielding has greater density (11.35 at 20°C) than any material anywhere near its cost—a worthwhile advantage when *space* and *money* are limited.

Where circumstances necessitate re-working or re-shaping standard on-hand lead brick, slab, pipe or sheet, a melting point of 327.4°C and excellent ductility are advantageous.

As a leading producer of "everything in lead," National Lead offers you unmatched resources and resourcefulness in meeting your lead shielding problems.

National Lead Shielding

NATIONAL LEAD COMPANY. New York 6; Atlanta; Baltimore 3; Depew (N.Y.); Chicago 80; Cincinnati 3; Cleveland 13; Dallas 2; Philadelphia 25; Pittsburgh 12; St. Louis 1; Boston 6 (National Lead Co. of Mass.); Los Angeles 23 (Morris P. Kirk & Son, Inc.); Toronto, Canada (Canada Metal Company, Limited).

WHAT'S NEW

Bed n' Sofas for Nurses' Homes

A unit for nurses' homes and other quarters where it is an advantage to have a sitting room during the day and sleeping facilities at night is offered in the Bed n' Sofa. This new line stands 5½



inches off the floor on specially constructed legs for attractive modern appearance and ease of cleaning. The new sofa beds blend with any room design and are available in a number of designs to harmonize with other furniture. They can be obtained in any style of fabric and color and provide comfortable seating and sleeping. **The Englander Company, Inc., 75 E. Wacker Drive, Chicago 1.**

For more details circle #811 on mailing card.

Nylon Elastic Stocking Has Full Foot

Sheer, sleek appearance is possible with the new Bauer & Black fashioned nylon stocking with full foot. Helanca processed nylon yarn, such as is used in ordinary nylon hosiery, is used in the new two-way stretch elastic stocking. Use of the new yarn eliminates toe cramping and a non-rubber heel of Helanca anchors the foot section in place. The toe section conforms to the natural contours of the foot for complete comfort.

Designed to conform to medical requirements for satisfactory elastic stocking performance, the new model gives greatest support at the ankle with pressure diminishing gradually up the leg. The new stocking is available in three sizes, in an attractive modern shade. **Bauer & Black, 309 W. Jackson Blvd., Chicago 6.**

For more details circle #812 on mailing card.

Fast-Drying Wall Finish Is Easily Applied

The finish coat can be put on the wall two hours after Paintercraft P.V.A. Fast-Dri Wall Primer and Sealer has been applied. This fast drying primer-sealer offers maximum ease of application and may be brushed, rolled or sprayed on. It provides a perfect foundation for flat paints and semi-gloss and gloss enamels. One gallon covers approximately 400 square feet. **The Sherwin-Williams Co., 101 Prospect Ave., N.W., Cleveland 1, Ohio.**

For more details circle #813 on mailing card.

Waste Disposers for Heavy Duty Applications

Four new powerful models have been added to the line of institutional Waste King Pulverators. Designed for heavy volume food service, the units are capable of pulverizing up to 2000 pounds of mixed garbage per hour. Each of the four new models comes complete with all necessary controls and fittings and is designed to fit the needs and locations of most institutions. **Given Mfg. Co., 3301 Fruitland, Los Angeles 58, Calif.**

For more details circle #814 on mailing card.

Floor Space Saved With Utility Column

A utility stand that takes up practically no floor space is offered in the Polecat Utility Column. It can be used in operating and recovery rooms, between beds and wherever supplies are needed and space is at a premium. The light weight 1½ inch pole easily supports 11 by 16 inch aluminum trays and infusion bottles on swinging stainless steel arms. The telescoping spring pole is adjusted to the ceiling height once, locked in



place with a safety collar, and is ready for attaching trays or bottles. They click in and out of place easily, yet are secure from being knocked off. When no longer needed the Polecat is easily taken down. A special foot prevents the pole from turning while in use. **Polecats, Inc., Old Lyme, Conn.**

For more details circle #815 on mailing card.

Fyrate Systems for Acoustical Fireproofing

Engineered and developed to provide architects with means to use mechanically suspended acoustical tile and still be able to meet Building Code requirements for fireproofing, Fyrate Systems provides a two hour fire resistive treatment in addition to true level and permanent acoustical tile installation. Tested and approved by Underwriters' Laboratory, Fyrate Systems also greatly reduces air conditioning loads as all plunum spaces are insulated from the usable or air conditioned spaces with the equivalent of four inches of mineral wool. **Fyrate, Inc., 823 W. Eastman St., Chicago 12.**

For more details circle #816 on mailing card.

(Continued on page 240)

Dry Bleach Has "Built-In" Safety

Wyandotte Halox dry bleach is designed to be completely safe for use on linens. A "built-in" safety factor stops tensile-strength loss due to bleach, according to the manufacturer, and releases chlorine as it is being used. Halox bleaches at regular bleaching temperatures in normal time without damaging fabrics. Stain removal and whiteness result from the use of Halox which is added dry to the wash. Accidental spilling on fabrics or skin does not damage and the product is easy to use and to measure. **Wyandotte Chemicals Corporation, J. B. Ford Div., Wyandotte, Mich.**

For more details circle #817 on mailing card.

Temperature Control Panel Is All Electronic

An all electronic temperature control panel which is easy to install and service has been added to Dunham's Vari Vac line of automatic temperature control equipment and systems. All moving parts are contained within a single, compact amplifier unit. No wiring connections need be broken within the panel in the installation or removal of the amplifier unit. The plug type electrical connection suffices. **C. A. Dunham Co., 400 W. Madison St., Chicago 6.**

For more details circle #818 on mailing card.

Sta-Kold Refrigerator Has Interchangeable Interiors

Interchangeable interiors that are adjustable in one inch centers are a feature of the new Sta-Kold Model RDA-40-S Dough Retarder-Salad Refrigerator. Designed to take any combination of pan slides, stationary or pullout meat rails and stationary or pullout shelves and biological drawers, the new refrigerator has all metal construction. The interior accessories can be changed in a matter of minutes, without the use of tools, to fit any requirements.

The refrigerator has a capacity of 40 cubic feet with a tray capacity equipped



with 53 sets of slides adjustable on one inch increments. The bottom is easily cleaned, top, sides, back and interior are of corrision-resistant aluminum, and there are two doors. **Victory Metal Mfg. Corp., Plymouth Meeting, Pa.**

For more details circle #819 on mailing card.



Lloyd St. Joseph Hospital, Menominee, Michigan
Architect—Harry W. Gjelsteen, Menominee, Michigan
Contractor—Proksch Construction Company, Iron River, Michigan

PLANNING A NEW HOSPITAL?

Here's where Natco ceramic glaze Vitritile enters the picture. This permanent, load-bearing unit is completely fireproof, while serving also as a beautiful sanitary, interior finish. Soap and water keeps it clean. A wide range of restful colors lend modern charm to the quiet interior atmosphere.

Be sure to introduce Natco ceramic glaze Vitritile when hospital plans are discussed. You can specify it with confidence—for corridors, operating rooms, wash rooms, cafeterias and partitions.

NATCO STRUCTURAL CLAY PRODUCTS

VITRITILE
Natco ceramic glaze Vitritile is available in 3 series . . . "6T," nominal face size 5⅓" x 12"; "8W," nominal face size 8" x 16"; and "4D," nominal face size 5⅓" x 8". Twenty scientifically engineered colors available. Complete line of fittings in this germ-proof, sanitary unit.





STAIRTREAD TILE
Long wear, low cost and simplified stair design make this unit increasingly popular. Rugged, fireproof and highly resistant to abrasion. Simplification of steel underframe saves up to 50%. Easy to install; easy to keep clean.

DRI-SPEEDWALL TILE
An exterior unit with 8-inch wall thickness; highly impervious to moisture penetration; completely fireproof. Automatically insulates the building, keeping interiors cool in summer, warm in winter. Available in manganese spot, buff unglaze and salt glaze finishes.





UNIWALL FACING TILE
Furnished in nominal 8" thickness for complete single unit wall construction. The exposed faces of the units, when in place, have unglaze rugg-tex exterior finish in a buff range, and ceramic glaze interior finish. Made of hard-burned deaired fire clay.

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327 Fifth Avenue, Pittsburgh 22, Pa.

Write today for more information on the complete line of Natco Structural Clay Products.

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"TWICE AS MANY RECORDS IN THE SAME SPACE"

in HALF the time



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Stormont-Vail Hospital, Topeka, Kansas
University of Maryland Hospital, Baltimore
University of Oklahoma Hospital, Oklahoma City
Receiving Hospital, Detroit, Michigan
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University of Minnesota Hospital, Minneapolis
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Use of a new Swedish steel of high carbon content and unusually fine grain assures precision-performance in every "Master Blade" for the Master Hand.

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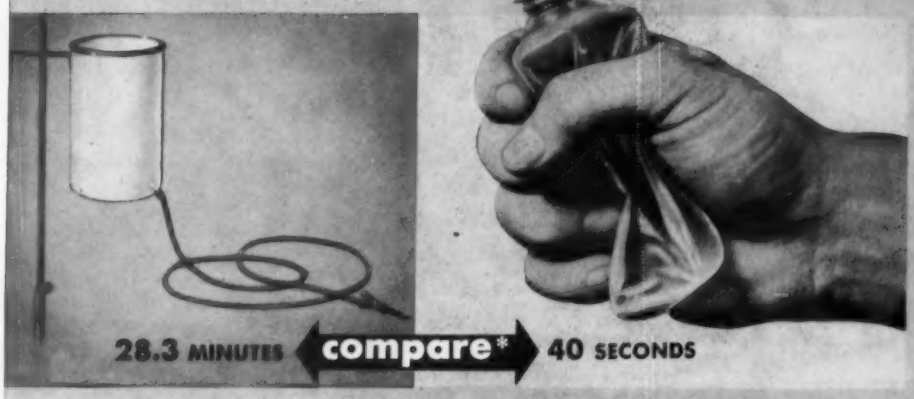
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It takes only *40 seconds* to prepare and administer a routine enema with the Fleet Enema Disposable Unit. Using cumbersome, old-fashioned equipment, preparation plus instillation plus "clean-up" and sterilization consumes *28.3 minutes.*

Only FLEET ENEMA Disposable Unit *offers these conveniences* . . . one hand administration . . . sanitary, individually sealed rectal tube . . . built-in rubber diaphragm to control flow, prevent leakage.

Each individual 4½ fl. oz. unit contains, per 100 cc., 16 gm. sodium biphosphate, and 6 gm. sodium phosphate, an enema solution of Phospho-Soda (Fleet) . . . gentle, prompt, thorough.



**From a soon-to-be-published time-cost study.*

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Never mind... it's

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–the folding chair with the weather-proof "AUTOMOBILE" FINISH!

SAMSONITE ALL-STEEL FOLDING CHAIR Six smart colors. Model #2600

And that means it resists rusting, scuffing, or fading—just like your car. It's one of many reasons why group seating experts choose Samsonite *first*... why Samsonite is America's public seating favorite, by millions!

Only Samsonite gives you all these EXTRAS AT NO EXTRA COST! Tubular steel construction • Easy, one-finger folding • Safety-Guard Hinges • Compact storing • Posture-Curved Comfort • Won't tilt or wobble • Low in cost.

SPECIAL QUANTITY PRICES from your Samsonite Distributor; or write us. Ask for our new *Free* booklet: "How to Save Money on Public Seating."

WRITE FOR SAMPLE CHAIR on your letterhead. Try it, test it. No obligation.

NEW LOW COST FOLDING CHAIR has compound curved back and 5-ply wood seat for extra durability. Newly designed seat support of rugged tubular steel, same as the frame, insures extra strength and serviceability. Model #2075—folds thin, stores compactly.





NEW SAMSONITE BANQUET TABLE opens quickly, smoothly. Foolproof leg locks. Folds to just 2⅛" *thin!* Masonite or Lifetime Plastic tops. 6 ft. (#4600); or 8 ft. (#4800) lengths.

LOOK FOR THIS SEAL on the back of your folding chairs. It identifies a *genuine* Samsonite chair.

SHWAYDER BROS. INC. Samsonite FOLDING CHAIR



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...the folding furniture that's strongest...lasts longest!

SHWAYDER BROS., INC., PUBLIC SEATING DIVISION, DEPT. S4, DETROIT 29, MICHIGAN

Also makers of famous Samsonite Luggage... Card Tables and Chairs for the Home... Classroom Furniture

WHAT'S NEW

Automatic Safety Features in Wall Outlet Assemblies

A new type flange-anchored wall box is offered in the new wall outlet assemblies for low pressure oxygen piping systems. The outlet becomes a permanent part of the wall and remains securely in place despite the strain and pull of vacuum bottles, humidifier and other



heavy equipment. A safe, fast and simple method of use is offered which protects the patient, saves time for personnel and safeguards equipment.

The entire valve assembly is completely recessed behind the wall plate, which is flush with the wall in concealed-pipe installations. A positive gas seal is provided by the valves when in use or idle. Administering equipment connects instantly, automatically opening service for use. A touch of the release button disconnects equipment for straight out removal. An exclusive, secondary safety device holds equipment safely in case of careless handling. The new outlets are available for oxygen, nitrous oxide, compressed air and vacuum service. Each type may be ordered alone or in multiple combination, for either concealed or exposed pipe systems. **Puritan Compressed Gas Corp., 2012 Grand Ave., Kansas City 8, Mo.**

For more details circle #820 on mailing card.

Modern Patterns in Stainless Steel Flatware

Two new patterns are available in stainless steel flatware for institutional use. The new Accent pattern in Oneidacraft Stainless has satin smooth surface which keeps its attractive appearance without special polishing. The design is simple and modern. The attractive new pattern is strong and sturdy for long wear.

The second pattern, in Oneida Stainless, is the Fernwood. The attractive design should be pleasing to patients and personnel and the solid stainless steel, polished to a hard finish, resists everyday usage. **Oneida Ltd., Hotel and Restaurant Div., Oneida, N.Y.**

For more details circle #821 on mailing card.

(Continued on page 244)

Standby Power in O.R. only, *is not enough!*



Let ONAN Standby Electric Plants supply power for all your essential services

Patients, hospital personnel and property may be endangered when any other vital equipment cannot be operated or important service performed . . . especially when the power outage is of long duration.

From the wide range of Onan Electric Plants you can choose a model with the capacity to operate *all essential equipment* . . . automatic heating system, respirators, aspirators, X-ray machines, ventilators, communications, pumps, elevators and lights *for as long as you need these services.*

When power interruptions occur, the Onan Emergency Power System takes over automatically . . . supplies electricity for the duration of the outage . . . and transfers the load back to the regular source of power when service is restored to normal.



MODEL 25HN
25,000 watts A.C.

Free Estimating Service

Let us know what equipment you would like to include in a complete emergency power system and we will recommend the proper equipment and estimate the cost. If you are building a new hospital or remodeling extensively, we suggest that you consult your architect or engineer.

ONAN ELECTRIC PLANTS *are available in a wide range of models and capacities—Gasoline-engine-powered: 400 to 100,000 watts, A.C.*

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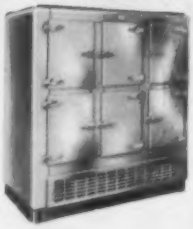
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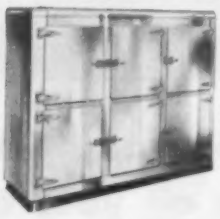
Stainless Steel Refrigerators, Freezers and Coolers

MODEL SS60B REACH-IN



Self-contained. For kitchen, bakery, pantry, or salad preparation. Capacity, 55.8 cu. ft. Exterior dimensions: 78" wide, 32" deep, 76" high. Accommodates 18x26" serving trays. Also made in 4-door model. Available in white baked enamel-porcelain as well as stainless steel.

MODEL RSS66 REACH-IN



For remote installation. Assures complete food conditioning. Capacity, 62 cu. ft. Exterior dimensions: 82" wide, 32" deep, 71" high. Also made in 2-door, 4-door and 8-door models. Offered with glass doors, if desired. Available in porcelain enamel as well as stainless steel.

MODEL SS40FP UPRIGHT FREEZER



Self contained. Designed to meet the most rigid commercial demands. Capacity, 40.2 cu. ft. Exterior dimensions: 68" wide, 32" deep, 76" high. Also made in 20 and 30 cu. ft. models. Available in white enamel finish as well as stainless steel. Remote type freezers are available, if desired.

MODEL 8885 WALK-IN COOLER



Permits economical bulk buying for menu diversification. Exterior dimensions: 8' wide, 8' deep, 8' high. Shown with white baked enamel finish on steel. Also available clad with stainless steel. Many other sizes can be obtained in single or multiple compartments.

SEE US AT THE NATIONAL RESTAURANT SHOW, BOOTHS 1536 AND 1537.

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In St. Louis, the Barnes Group Hospital had a mass of paper work to cope with. So it installed the latest Dictaphone dictating equipment to save the valuable time of doctors and administrators.

TIME-MASTER dictating machines in doctors' offices are always instantly ready. Simply pick up the hand mike and dictate information while it's fresh.

TELECORD network dictation makes the same instant dictating available throughout surgery. TELECORD stations are telephone hand-sets with buttons for start and stop, corrections and playback. In a centrally located typing pool, TIME-MASTERs record the dictation on crystal clear *Dictabelt* records.

PBX TELECORD dictation is available to all administrative officials of Barns Hospital on their regular telephone hand-sets. They simply dial a special number and dictate. No extra telephone sets or new wiring is required.

Your hospital can save time and money the efficient Dictaphone way, just as the Barnes Group Hospital has. Mail the coupon for illustrated folders on the Dictaphone dictation systems.



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DICTAPHONE, TIME-MASTER, DICTABELT AND TELECORD ARE REGISTERED TRADE-MARKS OF DICTAPHONE CORPORATION

WHAT'S NEW

Rubbermaid Shelving Prevents Slippage

A new type of shelving is available which is resistant to hot water, detergents and grease. Known as Rubbermaid Shelving, it is designed to lie flat without curling and has a ribbed surface design that prevents slippage and protects against breakage. It is available in widths of 11¾ and 22 inches in 30 and 60 foot rolls. **Rubbermaid Div., The Wooster Rubber Co., Wooster, Ohio.**

For more details circle #822 on mailing card.

Nylon Forceps Jars Are Quiet and Rugged



Forceps jars in two sizes are now available in Dupont "Zytel" Nylon. They are light in weight, do not crack, chip or peel, are tough and rigid and are quiet in use. Nylon is warm to the touch and will not injure or scratch instruments. The jars can be autoclaved, sterilized with cold sterilizing agents, boiled or washed in a dishwasher. They resist alcohol, alkalies and dilute acids in general use in hospitals. The new nylon jars are offered in tube depths of 7¼ and 4⅜ inches, 2¼ inches in diameter, and are available in aqua or gray. **Zylon Products Co., 27 Dryden Lane, Providence 4, R.I.**

For more details circle #823 on mailing card.

Liquid Graphite Pencil Has Unbreakable Point

Liquid graphite is used in a new pencil which cannot wear or break its point. Since the writing tip of the new pencil is not affected by wear, the line width does not vary. More than six times as much writing as a conventional lead pencil is promised from the new tool. The new liquefied graphite in suspension is described as having writing characteristics identical to graphite in solid form except that it does not smudge. The permanent writing tip has the same linear width as a sharpened lead pencil, the dimensions and forms of the new pencil being determined by research conducted by the manufacturer with the University of Wisconsin over a two year period. **The Parker Pen Company, Janesville, Wis.**

For more details circle #824 on mailing card.

Room Air Conditioner for Narrow Windows

A new inside-the-glass line room air conditioner has been developed which can be installed on narrow windows, down to 33½ inches wide. The unit rolls easily on tracks, giving easy access to the window for washing and other maintenance. The entire unit can be installed or rolled away from the window by a simple procedure.

The multi-purpose room air conditioner is available in ½, ¾, 1 and 1½ h.p. units and cools or warms as conditions require. The self-contained unit is completely inside the room, eliminating over-hang. The window sash can be completely lowered or raised behind the unit which need not be stored in winter. **Perfection Stove Co., 7609 Platt Ave., Cleveland 4, Ohio.**

For more details circle #825 on mailing card.

Micro-Projector Is Simple in Operation

True-color microscope specimens are easily projected for group study with the new SpeedMatic Micro-Projector. It operates as simply as an ordinary slide projector without the necessity for lens changing, condenser focusing or arc lamp adjustments. It produces clear images and can be operated by anyone with a few minutes of instruction. The carbon light system is designed to give a full hour of uninterrupted, dependable uniform illumination once the carbons have been clipped into position. The Electronic-Feed Illuminator is almost



completely automatic, permitting the operator to concentrate on the material presented.

The new model provides a practical range of magnification for instruction, demonstration and observation and affords versatility in choice of magnifications and field of view. The built-in mechanical stage permits precise positioning of the specimen. The projector is streamlined and attractive in appearance and efficient in operation. **Bausch & Lomb Optical Co., Rochester 2, N.Y.**

For more details circle #826 on mailing card.

(Continued on page 246)

The best actually costs less



Farmington Pattern No. 8303, 10 oz.

STANLEY *it will not break!*

STANLEY SERVERS save you money by reducing breakage and replacement costs! Their nickel silver outer shells and stainless steel interiors mean that they can never break! Wide mouth openings make Stanleys easy to clean and sterilize. Exhaustive tests have proved they retain temperatures longer. For the complete facts on genuine Stanleys, write us today!

STANLEY INSULATING DIVISION
of Landers, Frary & Clark, New Britain, Conn.

TRAPPED! A TRAGEDY OF NO ESCAPE



This Could Have Been Avoided With Chamberlin Psycho-Security Screens With Outside Emergency Lock Releases

Yes, Chamberlin hinged Psycho-Security Screens in place of bars and fixed wire guards, are indeed a modern protection when equipped with emergency lock releases. They insure against the tragedy of no-escape in case of fire, and thus they go a long way toward reducing the hazard of public liability damage suits, and public investigations.

CHAMBERLIN HAS INSTALLED MORE PSYCHO-SECURITY SCREENS THAN ALL OTHER COMPANIES TOGETHER

In the Psycho-Security Screen field Chamberlin leads in design, engineering, manufacturing and advisory know-how. You can depend upon the ethics and the service to be expected from a concern that's been in business 57 years.



3 TYPES MEET PATIENT NEEDS

Detention (1) To withstand the fury of violent attack.
Protection (2) For the less violent patient.
Safety (3) For mildly disturbed patients requiring protective custody.

WHAT PRICE PEACE OF MIND?

In addition to these emergency values, Chamberlin Psycho-Security Screens are like a firm hand in a velvet glove in the endeavor to bring peace and ultimate recovery to disturbed patients.

They imply no sense of restraint because they look like an insect screen and, in fact, function as such. Yet the high-tensil, shock-absorbing, stainless steel mesh insures against damage to windows and hazards of self-injury, suicide and escape.

Insist on

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unequalled for security

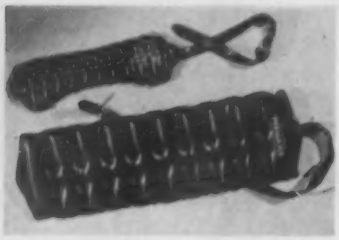
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CHAMBERLIN INSTITUTIONAL SERVICES also include Mineral Wool Insulation, Metal Weather Strips and Caulking, Metal Combination Windows and Doors, Metal Insect Screens, Aluminum and Fiber Glass Awnings.

WHAT'S NEW

Medic-Paks for Therapeutic Applications

Either hot or cold applications are possible with the permanently-sealed Medic-Paks. Containing a stable, non-toxic, odorless gel which never turns liquid and retains heat or cold, the packs are



sealed in soft, durable vinyl plastic. It cannot leak, even if punctured, and is comfortable in application.

The Medic-Paks may be rolled up to save space and may be heated or frozen anywhere in a minimum of time. They deliver a maximum amount of heat or cold and retain the temperature for long periods. The segmentation design keeps weight evenly distributed without shifting and permits easy wrapping around any body contour. Built-in straps keep the Medic-Paks in position. **"Bud" Wilson, Inc., 232 S. Beverly Drive, Beverly Hills, Calif.**

For more details circle #827 on mailing card.

Color System for Tinting Paint Bases

A universal tube system of colorants has been developed for use with white and neutral paint bases to provide 300 colors. Known as Maestro Colors, the colorants provide instant color dispersion in both latex and alkyd tinting base paint materials. The simplified system is being offered in three Pittsburgh paint lines: Wallhide Rubberized Satin Finish, Satinhide Enamel and Wallhide PBX Flat Wall Paint.

A color chip rack makes color selection easy. Color tubes are furnished in one-quarter, one and four ounce sizes. Colors are mixed in the indicated amounts in the white or neutral paint bases for the desired shade. **Pittsburgh Plate Glass Company, 632 Duquesne Blvd., Pittsburgh 22, Pa.**

For more details circle #828 on mailing card.

Institutional Cleaning Pads for Kitchen Utensils

Brillo Soap Pads Hotel Size provide a fast and convenient way to clean cooking utensils, stove ovens, grates, counters and all other metal surfaces around the large institutional kitchen. The new pad is four and one-half inches square and is impregnated with pure vegetable oil polishing soap. The combination of the sturdy metal fibers and polishing soap removes food particles and burned-on scorch at the same time grease is dissolved. **Brillo Mfg. Co., 60 John St., Brooklyn 1, N.Y.**

For more details circle #829 on mailing card.

Solar Glass Block Protects Against Excessive Heat

Designed especially for use in areas with severe sun conditions, the new Owens-Illinois No. 80-F solar glass block rejects unwanted solar heat and light. The special-purpose glass block is designed for southern exposures to protect against undue heat and light when the sun is at or near 45 degree altitude. Above and below the 45 degree band acceptance of light gradually increases and the block is particularly efficient in transmitting cool ground reflected light.

The construction of the new solar glass block is such that light is reflected rather than absorbed, without entering the block, thus protecting against the sun's rays. The No. 80 matching block, designed for maximum utilization of cool north light, omits the diffusing screen in the center. **Kimble Glass Company, Toledo 1, Ohio.**

For more details circle #830 on mailing card.

Simplified Controls on Edin Electrocardiograph

Model 250 Edin Electrocardiograph was designed to exceed A.M.A. requirements for accurate diagnosis, according to the manufacturer. It is linear to both large and small signals. The simplified controls are placed for complete right



hand operation, eliminating hand crossover and making the graph constantly visible. Accurate QRS complexes are provided and complete definition is possible regardless of wave form height or deflection speed. Clear, accurate graphs are provided by a high interference rejection ratio. The machine is light in weight for easy portability and is designed for simple, precise operation. **Edin Company, Inc., 207 Main St., Worcester 8, Mass.**

For more details circle #831 on mailing card.

(Continued on page 248)

BARBER COLMAN

UNI-FLO ENGINEERED

Double Deflection Grilles

. . . adjustable, tamperproof!

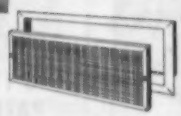
- Assure you rapid diffusion without the discomfort of air stream drop
- Permit greater temperature differentials—resulting in economies in duct work and equipment space
- Laboratory designed, engineered and tested—guaranteed performance in accordance with published engineering data
- Guard against tampering — rigid steel frame attached to duct inside skirt, core may be attached to frame with tamperproof screws — closely nested fins add strength, are not easily plugged with paper and other objects. Ideal for schools and other institutions
- Available with opposed blade volume control, key-operated from face of the diffuser, provides easy system balancing, prevents unauthorized tampering



(Above) Integral volume control, an extra, adjusted with key. (Left) Tool positions vertical fins.



(Right) Reversing or inverting core provides variations of vertical deflection.





DATA BULLETIN, F-3717-3, now available. Consult nearby Field Office, or write . . .

Barber-Colman Company

Dept. Q, 1146 Rock Street — Rockford, Illinois, U. S. A.

Huge School System

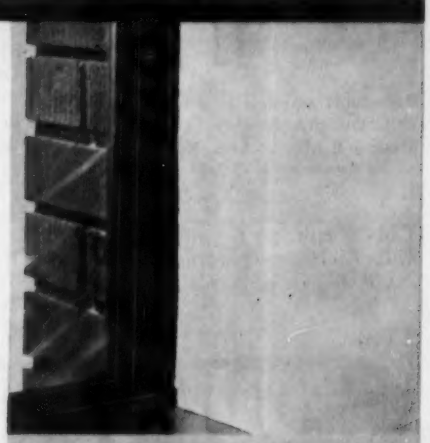


Lecks were serious in this older school, so brick was repointed then coated with silicone repellent. Results: Weatherwise, the school is better than new!



Here's the kind of damage to interiors that driving rain, soaking right through the wall, can cause inside of six months.

Approves Silicone Masonry Water Repellent



AFTER "invisible raincoat" made with LINDE Silicones was applied outside, the same type paint used before was in perfect condition after another six-month period.

A remarkable "invisible raincoat" is already protecting a half million square feet of wall, on over 30 of the 300 schools in a great eastern city. Known as "above-grade masonry water repellent," it is made with LINDE Silicones.

The school system's maintenance engineers report that it is easy to use and lastingly effective. Besides treating many older schools, they are applying it to all new schools as erected.

Rain leaks and seepage are ended, eliminating costly damage to interior plaster, paint, and woodwork. Masonry damage due to water absorption and freezing has been stopped. Rain simply washes dirt right down to the ground.

Above-grade masonry water repellents made with LINDE Silicones dry in three hours to a colorless, shineless finish. They reach the correct depth for maximum effectiveness. They let walls "breathe" so moisture entrapped before treatment can escape.

No wonder more and more brick, masonry and concrete buildings of all types now wear "invisible raincoats" made of LINDE Silicones! Write for full details and a list of representative suppliers. Address Dept. F-5.

FOR SILICONES LOOK TO

Linde AIR PRODUCTS COMPANY | A DIVISION OF UNION CARBIDE AND CARBON CORPORATION

General Offices: 30 East 42nd Street, New York 17, N.Y.

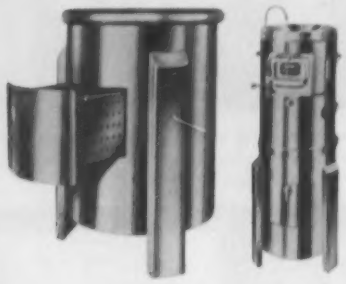
IN CANADA: Dominion Oxygen Company, Division Union Carbide Canada Limited

The term "Linde" is a registered trade-mark of Union Carbide and Carbon Corporation

WHAT'S NEW

Peel Trap Base Permits Permanent Installation

The new Univex stainless steel Peel Trap Base is designed as an accessory to convert any portable Univex peeler into a floor model for permanent installation. Univex portable peelers may be bolted to the top of the new base with provision for peeling waste to be filtered into a stainless strainer within the base. Heavy satin finish stainless steel is used for construction of the new base which has



adjustable stainless legs to accommodate different sink heights. **Universal Industries, 360 Mystic Ave., Somerville, Mass.**

For more details circle #832 on mailing card.

Cold Sterilizing Agent Kills All Micro-Organisms

An effective germicidal, fungicidal and virucidal product which is non-toxic and non-irritating when used as directed is offered in Warexin. Containing Clorpactin (R), Warexin is a cold sterilizing agent which kills all micro-organisms such as virus, bacteria, spores and fungus. It is effective for cold sterilization and deodorization of instruments, equipment and all materials, including labile rubber goods, plastics and synthetic fibers.

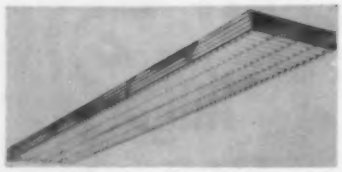
Other grades and solutions of Clorpactin, a white, water-soluble powder or granules, are effective as sterilizing agents for external purposes in dermatological applications, for use in oral and dental hygiene, for irrigation of wounds and body cavities, for treatment of deep-seated infections, and for other sterilization procedures. **The Guardian Chemical Company, 10-15 43rd Ave., Long Island City, N.Y.**

For more details circle #833 on mailing card.

Shallow, Slim Fixture Offered in Louverlite

Only slightly more than three inches in depth, the new Louverlite Slimline has clean, slim lines for beauty as well as even, comfortable and direct illumination. The new lighting fixture is available in 4 and 8 foot units for two or four T-12 430-MA lamps. The two or four Rapid Start Bi-Pin Louverlite is also available and the unit may be purchased

(Continued on page 252)



with steel or translucent plastic inserts.

The Louverlite Slimline is designed for totally direct light distribution but removable sections in the top reflector permit varied uplighting effects if desired. The new unit can be mounted individually or in continuous rows, surface or pendant mounted. Louvers are hinged from either side for easy maintenance. **Smithcraft Lighting Division, Chelsea 50, Mass.**

For more details circle #834 on mailing card.

Buttermilk Powder for Cooking and Baking

Cheflac is a cultured buttermilk powder made from country fresh sweet cream butter. It is inexpensive and is designed for use in baking and cooking to improve quality and flavor. It can be used in soups, sauces and gravies and has a controlled acidity. Cheflac is packed in sealed #10 and 14 ounce tins. **Webster Van Winkle Corp., 99 Summit Ave., Summit, N.J.**

For more details circle #835 on mailing card.

FOUL ODORS

VANISH LIKE MAGIC!



F. & E. SOLUTION, the modern deodorant and disinfectant, *neutralizes* foul odors and ammonia smells *instantly*, and replaces them with the pleasant, refreshing aroma of eucalyptus—so different from the usual harsh "just cleaned" disinfectant smell. Ideal for mopping and spraying.

F&E doesn't merely cover up bad smells—it *transforms* them into odorless compounds by modern chemical means.

One cupful added to your regular cleaning solution provides simultaneous cleaning and deodorizing. And F&E is *mighty economical!*

Write for literature, and ask your DOLGE SERVICE MAN to demonstrate the "Ammonia Test."

FOR FREE SANITARY SURVEY OF YOUR HOSPITAL SEE YOUR DOLGE SERVICE MAN

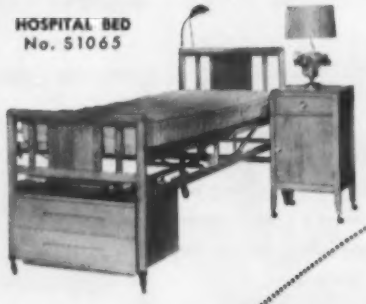
DOLGE

WESTPORT, CONNECTICUT

HOSPITAL and DORMITORY BEDS

with Large, Deep Drawers

HOSPITAL BED No. 51065



Solid birch construction Width: 3'-0". Length: either 6'-5" or 6'-8". 3" rubber wheel ball bearing casters. Chest is 36" x 20" x 15".

Write for Bul. HB-54



Solid birch construction. Width 3'-0". Length: 6'-6". 1⅝" rubber wheel — ball bearing casters. Chest is 36" x 20" x 15".

Write for Bul. DB-54

DORMITORY BED No. 1065 DB

IF YOU HAVE A "HIGH-LOW" BED REQUIREMENT . . .

Check with us on the most practical and economical solution.

EICHENLAUBS Contract Furniture

3901 BUTLER ST., PITTSBURGH 1, PA.

E-9

NEW HELP WITH YOUR

DIRTY FLOORS

WHITE UTILITY TRUCKS

ALL PURPOSE . . . TRUCKS

This Truck will carry all the cleaning equipment needed to make your floor cleaning job an easy one. Mops, brooms, buckets, wringers, etc. and soaps, dust cloths, polish, waxes, all fit conveniently on this specially designed truck. Large trash bag slides out of the way when not in use. Rolls silently on rubber wheels.



PICK-UP . . . . . TRUCKS



An Ideal truck for quick and easy collection of waste paper, trash and soiled linen. Moves silently on either 2 or 4 rubber wheels. Has large carrying capacity, approximately five bushels, and can be folded flat for storage. Saves hours of labor in schools, offices and public buildings.

HANDY TRUCKS . . .



WHITEY MOPZUM SAYS:



This Handy Truck is a tremendous time and money saver around any institution. For moving garbage cans, ash cans, cartons or any other heavy equipment with a minimum of time and effort. Sturdy construction yet light in weight. Soft tread on wheels for quiet operation.

Write for Catalog No. 153

WHITE MOP WRINGER CO.
9 Mohawk St., Fultonville, N.Y.
Canadian Factory: Paris, Ont., Canada

It's RIGHT . . . if it's

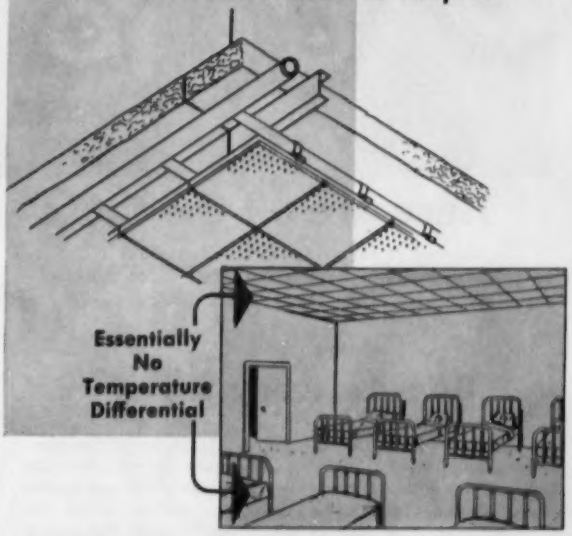


A COMPLETE LINE OF FLOOR CLEANING EQUIPMENT

The Greatest Advance in Room Comfort in many years

BURGESS-MANNING 3-Way Radiant Panel Functional Ceiling

The reason is simple!



This "most modern" of all ceilings combines Radiant Panel Heating, Radiant Panel Cooling, and Acoustic Control — or heating and acoustic control only, if desired — in one simple, economical and highly efficient method to offer a new standard of comfort that is ideally adapted to institutions and hospitals. Heat energy is radiated to or from the entire ceiling, to or from every surface or object in the room to provide an insignificant differential from floor to ceiling. Convection drafts and heat shadows are minimized — concentrated heat sources and overheated air are eliminated. Before your Board attempts a decision on the type of ceiling to be used in your new building or addition, and in remodeling programs, too — weigh carefully the rating of those institutions now having B/M 3-Way Radiant Panel Functional Ceilings. Above all, see and feel one in operation — *Know the facts.* Ask your architect to get all the facts!

Write for Bulletin A-129-M

Architectural Products Division of

BURGESS-MANNING COMPANY

5970 Northwest Highway, Chicago 31, Ill.

Manufacturers of 3-Way Functional Ceilings and Telephone Acousti-Booths

What do you know about buying casters?



Here are all the facts

All casters are *not* the same. They differ in quality of construction and material. They differ in the way they do their job. And they differ even more in durability.

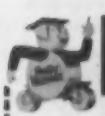
Be sure... buy Bassick

The safest way to buy casters is to specify Bassick's — made by the world's leading manufacturer of floor protection devices. We've made it easy for you with the catalog above. It's packed with specific facts and figures as well as clear illustrations of the complete Bassick line of institutional casters. It's in the Hospital Purchasing File, of course, but we'll be glad to send you a copy on receipt of the coupon.

For heavy-duty jobs

Another Bassick catalog (right) you'll find useful describes our casters with rubber-tired disc wheels — built for medium and heavy duty on trucks and similar equipment. A copy is waiting for you. The Bassick Company, Bridgeport 2, Conn. *In Canada:* Belleville, Ont.





Bassick
A DIVISION OF SW

The Bassick Company Bridgeport 2, Conn.

Please send me copy of catalog(s) checked:

☐ Bassick Institutional Casters Catalog HPF-54

☐ Bassick Rubber-Tired Disc Wheel Casters Catalog 4R-55

Name _____ Title _____

Address _____

City _____

State _____

Stimulate FUND RAISING



Style B
Solid cast bronze or aluminum tablet. Raised letters in bold relief contrasting with stippled oxidized background.



Style P
Raised letter cast bronze room plaque with double line border. Available in all sizes.

Plaques & nameplates in bronze, aluminum or plastic have been proved the ideal, dignified and most effective way to raise funds for hospitals.

By acknowledging contributions in this permanent manner you encourage future donors. Why not write us now for illustrations and prices. You'll be pleased by this economical and attractive way to give permanent recognition.

A FEW OF OUR MANY HOSPITAL ACCOUNTS*

*Baton Rouge Hospital
*Cerebral Palsy Hospital
*Anderson County Hospital
*Kings Daughters Hospital
*Mt. Sinai Hospital
*Sloan Kettering Institute

*Exact addresses furnished on request.

"BRONZE TABLET HEADQUARTERS"

UNITED STATES BRONZE SIGN CO., INC.

570 Broadway Dept. MH New York 12, N. Y.



I've Got An IDEA for YOU!

It's my job to pass on ideas and suggestions to save you time and money, aid labor, control portions, reduce work, improve your facilities. If you have any particular problem, perhaps I can bring you the benefit of the experience of others who may have had the same problem as yours. So a few minutes talk with me, may help solve it!

YOU CAN CHOOSE FROM 50,000 ITEMS

. . . everything you need in food preparation and serving equipment, maintenance of your premises, etc. The catalog I carry is chock full of *service merchandise*. DON carries a complete line—from ranges to toothpicks, plastic ware to potato peelers, linens and silverware to dishwashers and janitorial supplies. Whether your needs be large or small, usually I can take care of them immediately from the large variety of merchandise that DON is known for. On everything you buy at DON, Satisfaction is Guaranteed or your Money Back!

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Your DON Salesman

1400 N. Miami Ave Miami 32 — DON COMPANY — 27 N. Second St Minneapolis 1

2201 S. LA SALLE ST. CHICAGO 16



proudly stated on the back of every bottle of 7-Up is a story you should know

Read it carefully. That list of ingredients tells you something very important about this sparkling, crystal-clear drink.

With good reason, 7-Up is famous as the *All-Family* Drink—so pure, so good, so wholesome for people of all ages.

The source of the 7-Up flavor is a fragrant, natural oil in the peel of lemons and limes. From every batch of this flavor source, Seven-Up selects less than 5%, *the very essence*, as being delicate and pure enough to be used in the "fresh up" drink! Seven-Up is crystal-clear. No artificial flavor is used.

If you want a real thirst-quencher...

If you hanker for a cool, clean taste...

If you want a quick, refreshing lift...

Nothing does it like Seven-Up!

WHAT'S NEW

Pharmaceuticals

Serfin

Serfin is a pure crystalline alkaloid of Rauwolfia Serpentina for the treatment of hypertension. Because it is a single alkaloid, accurate dosage is attainable and uniform potency is assured. Serfin is supplied as scored tablets in bottles of 100 and 500. **Parke, Davis & Co., Jos. Campau Ave. at the River, Detroit 32, Mich.**

For more details circle #836 on mailing card.

Achromycin Pharyngets and Troches

Achromycin preparations for the control of superficial infections of the mouth and throat are offered in Achromycin Pharyngets and Achromycin Troches. These highly palatable preparations contain Achromycin Tetracycline HCl and are designed to dissolve slowly in the mouth. Both may be prescribed in conjunction with systemic Achromycin therapy in severe oral infections. Achromycin Troches are peppermint flavored, will not crumble and are packaged in bottles of 25 and 50. Achromycin Pharyngets are cherry flavored, individually wrapped in cellophane and foil, in boxes of 10. **Lederle Laboratories Division, American Cyanamid Co., Pearl River, N.Y.**

For more details circle #837 on mailing card.

Doriden

Doriden is a new nonbarbiturate hypnotic-sedative indicated in insomnia, presurgery sedation and for daytime sedation in anxiety-tension states. It is a new type of non-narcotic characterized by rapid onset, excellent depth of hypnosis and four to eight hours of physiologic sleep. In hypnotic dosage it is usually sleep-producing in 15 to 20 minutes. For daytime sedation dosage is adjusted to produce a calming effect without drowsiness. Doriden is supplied in scored 0.25 Gm. and 0.5 Gm. tablets in bottles of 100 and 500. **Ciba Pharmaceutical Products, Inc., Summit, N.J.**

For more details circle #838 on mailing card.

Mio-Pressin

Mio-Pressin supplies a three-way attack on mild, moderate or severe hypertension. It is a balanced combination of three anti-hypertensive agents: Rauwolfia, protoveratrine and dibenzyline, which provides comprehensive control over blood pressure-regulation mechanisms. Mio-Pressin is supplied in two dosage strengths as an aid in adjusting the dose to the individual patient. Side effects are usually mild and are controlled by careful adjustment of dosage schedules. **Smith, Kline & French Laboratories, 1530 Spring Garden St., Philadelphia 1, Pa.**

For more details circle #839 on mailing card.

Romilar

Romilar is an effective and safe cough-suppressing agent which has the antitussive activity of codeine yet is non-narcotic, does not constipate and is well tolerated. It is available in 10 mg double-scored tablets and in a syrup containing 10 mg per teaspoonful. **Hoffmann-La Roche Inc., Roche Park, Nutley 10, N.J.**

For more details circle #840 on mailing card.

Panmycin for Pediatric Dosage

Panmycin Drops and Panmycin Readimixed provide the broad-spectrum antibiotic tetracycline in pediatric dosage forms. Both products are fruit flavored and brightly colored for easy oral administration to infants and children. Panmycin Drops, for infants, is a stable, oral suspension containing 100 mg of tetracycline per one cc. It can be given directly by mouth or mixed with milk or fruit juice. Panmycin Readimixed contains 125 mg per 5 cc. of the antibiotic in a stable, orange colored oil suspension. It is administered orally to children or to adults who have trouble swallowing other forms. **Upjohn Company, Kalamazoo, Mich.**

For more details circle #841 on mailing card.

Robitussin A-C

Robitussin A-C provides the expectorant-antitussive action of glyceryl guaiacolate and desoxyephedrine hydrochloride augmented by the antihistaminic action of prophenpyridamine and the cough-suppressant effects of codeine. It is an "exempt narcotic" for the treatment of cough. Robitussin A-C is available in pints and gallons. **A. H. Robins Co., 1407 Cummings Dr., Richmond 20, Va.**

For more details circle #842 on mailing card.

Euphased-5 Tablets

Euphased-5 Tablets are a new and more potent dosage form of the stimulant-anoretic "Euphased." They are indicated as an appetite depressant in obesity and CNS stimulant in depressive states. Euphased-5 tablets are supplied in bottles of 100 and 1000 scored tablets. **Schenley Laboratories, Inc., 350 Fifth Ave., New York 1.**

For more details circle #843 on mailing card.

Marezine Lactate Injection

Marezine Lactate brand Cyclizine Lactate Injection, 50 mg in one cc, is indicated for the prevention and treatment of post-operative vomiting and intractable vomiting associated with pregnancy, vertigo and fenestration operations. It is available in boxes of 12 and 100. **Burroughs Wellcome & Co. (U.S.A.) Inc., 1 Scarsdale Rd., Tuckahoe 7, N. Y.**

For more details circle #844 on mailing card.

(Continued on page 254)

KITCHENS *Engineered* FOR EFFICIENCY

Hospitals today must be sure that every department operates at maximum efficiency, providing the ultimate in economy. This is specifically true of the food service equipment facilities. It is important, therefore, in order to achieve this, that the kitchens of a new hospital, or a hospital planning a renovation, be "engineered" by an organization specializing in such work, with the facilities to do the entire job.

The four firms listed below have been engineering outstanding hospital food service equipment installations for many years and they welcome your inquiries.



Oak Park Hospital, Oak Park, Illinois
Schmidt, Garden & Erikson, Architects
Kitchen installation by
ALBERT PICK CO., INC.

FOR COMPLETE SERVICE

NATHAN STRAUS-DUPARQUET — NEW YORK
ALBERT PICK CO. INC — CHICAGO
HOVEN, McDUFFEE & STRATTON CORP — BOSTON
THE MAXWELL CO., INC — MIAMI, FLORIDA

TODAY'S MOST MODERN
COMMERCIAL GAS COOKING
EQUIPMENT SPECIALLY
DESIGNED FOR MODERATE
SIZED KITCHENS



NEW

New features and styling, easy to keep clean and new-looking.

MODERN

Streamlined design throughout. Double-wall, double strength elevated shelf.

THRIFTY

Saves fuel. Saves operating time. Saves cleaning time.

DURABLE

Formed steel construction provides maximum strength. Welded joints are tight forever.

Available in Stainless Steel (as shown), Black Japan, or Lustre-Line gray finishes.

Magic Chef

CAFE LINE

commercial GAS cooking equipment

FOR INFORMATION WRITE Magic Chef, Inc., St. Louis 10, Missouri

WHAT'S NEW

Product Literature

• A 40 page illustrated catalog giving complete information on the Ohio-Heidbrink line of **"Surgical Anesthesia Apparatus"** has been published by Ohio Chemical & Surgical Equipment Co., Madison 10, Wis. Descriptive data on equipment and accessories making up the comprehensive line are given, including data on the recently introduced No. 60 Infant Circle Absorber, the Fink modification of the Stephens-Slater valve, recalibrated flowmeters and the more extensive line of intratracheal anesthesia accessories. Copies of the new catalog are available by requesting **Form No. 2145** from the company.

For more details circle #845 on mailing card.

• **"Guideposts to Better Air Conditioning Installations"** is the title of a 36 page booklet published by E. I. du Pont de Nemours & Co., 6529 Nemours Bldg., Wilmington, Del. A compilation of semi-technical articles by outstanding engineering consultants, **Booklet A-8726** contains helpful tips on ways to apply economical and efficient air conditioning to more than a score of different types of buildings.

For more details circle #846 on mailing card.

• **Techniques and Equipment for Parenteral Administration** are discussed in 52 page booklet prepared by Abbott Laboratories, North Chicago, Ill. Written in narrative style, the story starts with a brief history of transfusions and proceeds to techniques, with illustrations showing veins and their names, and drawings illustrating each step as it is discussed. Collection of blood and administration of intravenous solutions as well as injection techniques and products are other subjects covered by text and drawings. The booklet closes with a chart covering the clinical analysis of transfusion reactions.

For more details circle #847 on mailing card.

• The use and advantages of porcelain enamel panels are discussed in a 12 page brochure made available by Davidson Enamel Products, Inc., 1109 E. Kibby St., Lima, Ohio. Of special interest to administrators and architects wanting data on practical methods for porcelain enamel wall panel systems, the brochure on **"Davidson Architectural Porcelain for Free Expression of Building Design"** is illustrated by drawings and photographs showing installation of the product for interior and exterior facing and curtain wall paneling.

For more details circle #848 on mailing card.

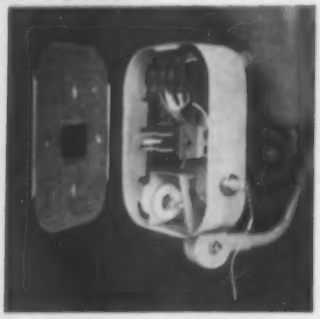
• **Triumph Vertical Food Mixers** are described and illustrated in a reference folder released by Triumph Mfg. Co., 3400 Spring Grove Ave., Cincinnati 25, Ohio. A section of the folder discusses the attachments available for use with the mixers.

For more details circle #849 on mailing card.

(Continued on page 256)

HOSPITALITY LIGHTS* cut costs up to $150. per room!

kurt versen



ONE OUTLET DOES WORK OF FIVE

Hospitality Lights' unique versatility enables a single unit to perform up to five electrical functions including reading light, night light, indirect light and two convenience outlets. Patented swivel actions permit finger-tip adjustments of reading arm to any angle. Switching combinations are virtually unlimited.

kurt versen



COMPLETE FLEXIBILITY OF APPLICATION

Hospitality Lights, the ultimate in versatility and lighting economy, originally were created by Kurt Versen for hospitals. Now they are available in twelve basic models and innumerable combinations for use in hotels, motels, institutions and in other applications where economy and flexibility are of major importance.

Visit Us At The Catholic Hospital Association Show in St. Louis

kurt versen company

Englewood, New Jersey, 11



Write today for latest bulletin on Hospitality Lights by Kurt Versen

Contemporary lighting creatively engineered!

*Completely covered by U.S. Pats. 2,617,619 and 2,667,571



GENUINE BRONZE

PORTRAIT TABLETS
HONOR ROLLS • NAME PLATES
DONOR PLAQUES
MEMORIALS produced to order.

LIGHTING FIXTURES

of Wrought Iron, Ornamental Bronze and Aluminum.



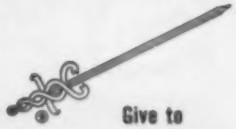
ESTIMATES AND ILLUSTRATED CATALOGS SENT ON REQUEST.

MEIERJOHAN-WENGLER
1102 W 9th St CINCINNATI 3, OHIO

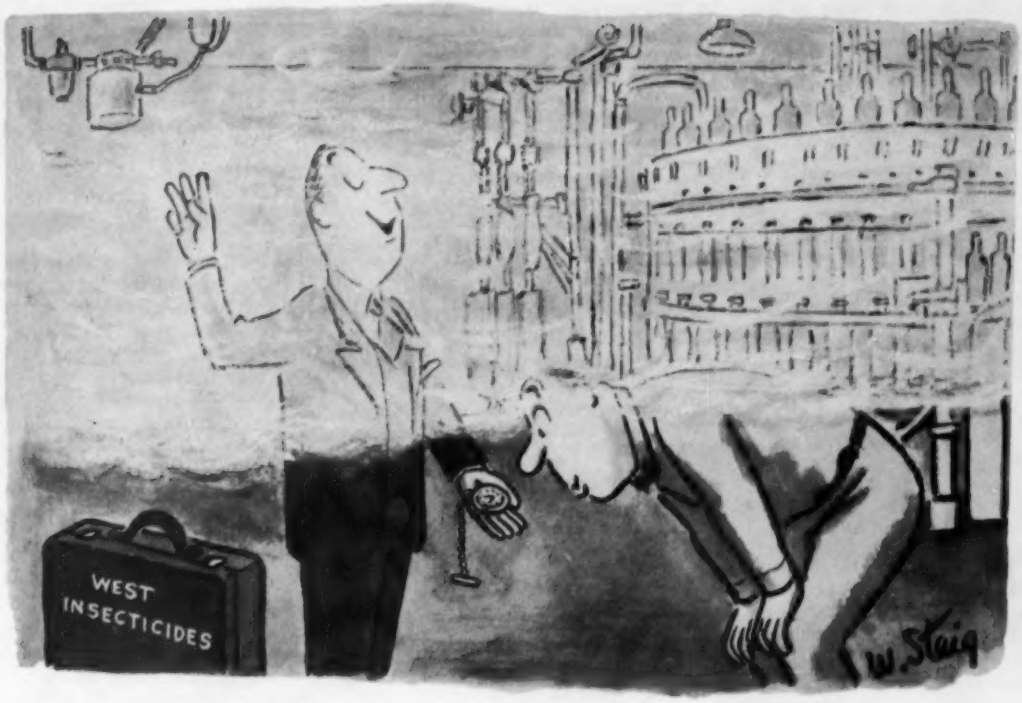
Don't sit back



STRIKE BACK!



Give to
AMERICAN CANCER SOCIETY



"See! Only 30 seconds to fog this room!"

THAT's how quickly you can control insects in 10,000 cubic feet of space with WEST ATOMIZERS and VAPOSECTOR insecticide.

Insects have no place to hide. VAPOSECTOR penetrates everywhere

— cracks
— crevices
— even remote hiding places.

Insects have no time to escape. VAPOSECTOR penetrates their outer skin for a quick, permanent kill. Yet it's safe to use. Odorless. Nontoxic when used as directed.

AND insect control is economical — when VAPOSECTOR is used in a WEST ATOMIZER. Only one or two ounces control all insects in 1,000 cubic feet of space

— in just 3 seconds
— at a cost as low as 5¢.

LET a West representative tell you more about West's *Insect Control Program*, equipment and insecticides. Many kinds and types are available. Or write for our 36 page booklet, *"Industrial Insect Control."*

OLDEST AND LARGEST COMPANY OF ITS KIND IN THE WORLD

WEST DISINFECTING Company

WEST DISINFECTING COMPANY Dept. 12
42-16 West Street, Long Island City 1, N. Y. *(Branches in principal cities)*
In Canada: 5621-23 Casgrain Ave., Montreal

☐ I'd like a free copy of your booklet "Industrial Insect Control."
☐ I'd like to have a WEST insect control specialist telephone me for an appointment.

Name_____

Position_____

(Tear out this coupon and mail it with your letterhead)

WHAT'S NEW

• A folder on the **Wall Mounted Room Air Conditioner** developed by the Airtemp Division of Chrysler, 1600 Webster St., Dayton, Ohio, tells the story of this new development in multi-room cooling. Copies of **folder ACC-191** giving information on installations of this new air conditioning device are obtainable from the Merchandising Department of the manufacturer.

For more details circle #850 on mailing card.

• **"The Answer to Many of Your Cleaning Problems"** is presented in a 12 page **Bulletin No. 154** published by The Spencer Turbine Co., 486 New Park Ave., Hartford 6, Conn. Cleaning costs, equipment and procedures for hospitals, schools, colleges and other large buildings are discussed in question and answer style, with charts, drawings and photographs to illustrate the points covered.

For more details circle #851 on mailing card.

• The full line of **"O.E.M. Oxygen Therapy and Respiratory Equipment"** is presented in the new **Catalog No. 10** released by O.E.M. Corporation, East Norwalk, Conn. Advances in the field and the new equipment designed to take advantage of them are described in the catalog which is fully illustrated. The 28 page booklet covers canopies, cough machine, flowmeter, humidifiers, nebulizers, oxygen masks and tents, regulators, testing equipment and parts and accessories.

For more details circle #852 on mailing card.

• "Nailock," "Screwlock" and "Perf-A-Best" systems for suspended ceilings are illustrated and described in **Catalog NSP-7** brought out by The Sanymetal Products Co., Inc., 1701 Urbana Rd., Cleveland 12, Ohio. Details on Utility Nailing Channel for light suspended ceilings are also included in the eight page catalog.

For more details circle #853 on mailing card.

• Selection technics for storage batteries for stand-by power, emergency lighting and switchgear applications are discussed in a 20 page manual released by Exide Industrial Div., The Electric Storage Battery Co., Box 8109, Philadelphia 1, Pa. The manual, **Bulletin 210,** also includes a discussion of charging equipment and maintenance technics in addition to an illustrated section on storage battery installation procedures.

For more details circle #854 on mailing card.

• The story of **"Registered Safety Mirrors"** for installation in schools, hospitals and other institutions, is told in a folder issued by Tyre Bros. Glass and Paint Co., 3010 San Pedro St., Los Angeles 11, Calif. Particularly designed for institutional use in public rest rooms and other areas where mirrors are used, the mirrors are shatterproof, moisture resistant and durable. They have stainless steel frames and are easy to hang.

For more details circle #855 on mailing card.

• **Bulletin LR-1,** covering Vogt Liquid Receivers, Ammonia and Freon, has been released by Henry Vogt Machine Co., 10th & Ormsby Sts., Louisville 10, Ky. Specifications are given together with charts showing data on the various sizes.

For more details circle #856 on mailing card.

• The physical performance of the new Suntrol Glass Block recently added to the line of functional glass blocks developed by Pittsburgh Corning Corporation, 1 Gateway Center, Pittsburgh 22, Pa., is discussed in a booklet recently released. Entitled **"Suntrol Glass Block for Reduction of Glare and Heat,"** the booklet illustrates the principle of Suntrol, which is made with a pale green diffusing screen to help reduce the intensity of glare and heat.

For more details circle #857 on mailing card.

• A brief history of roofing is presented in a humorous, cartoon-type manner in a new 20 page booklet, **"Roofing—Then and Now,"** published by Twinsburg-Miller Corporation, Twinsburg, Ohio. Extensive research went into preparation of the factual historical data on roofs which is presented. Also included is the story of modern Glasfab fiber glass roofing membrane.

For more details circle #858 on mailing card.

Book Announcements

Fulton and collaborators, "A Textbook of Physiology," 17th ed., 1275 pp., $13.50. Harrow, Borek, Mazur, Stone and Wagreich, "Laboratory Manual of Biochemistry," 4th ed., 164 pp., $3. McAllister, "Ethics With Special Application to the Medical and Nursing Professions," 2nd ed., 423 pp., $4. McKenna, "Thresholds to Professional Nursing Practice," 374 pp., $4.25. **W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa.**

For more details circle #859 on mailing card.

Suppliers' News

Licenses to manufacture and distribute in interstate commerce the poliomyelitis vaccine developed by Dr. Jonas Salk of the University of Pittsburgh have been issued to six pharmaceutical concerns, according to an announcement of the U.S. Department of Health, Education and Welfare. Licenses were released on April 12, 1955, in accordance with the Regulations of the National Biologics Control Act, and granted to the following requesting firms: **Cutter Laboratories, Berkeley, Calif.; Eli Lilly Co., Indianapolis, Ind.; Parke-Davis & Co., Detroit, Mich.; Pittman-Moore Co., Zionville, Ind.; Sharp and Dohme, Philadelphia, Pa.; and Wyeth Laboratories, Inc., Marietta, Pa.**

American Safety Razor Corporation's Hospital Division, 380 Madison Ave., New York 17, manufacturer of A.S.R. Surgical Blades and Handles, A.S.R. Double Edge Hospital Razor Blades, and A.S.R. Flushaway Disposable Bed Pan Covers, announces the completion of the new plant at **Staunton, Va.** The increased production facilities are approaching full-scale operation and improved laboratory and engineering facilities provide facilities for expanding the company's new product development program.

Beckman Instruments, Inc., Fullerton, Calif., announces the acquisition of **Specialized Instruments Corp. and Spinco Service Corp., both of Belmont, Calif.** To be known as the **Spinco Division of Beckman Instruments, Inc.,** the new company will manufacture and distribute a line of instruments for advanced research in the chemical, biophysical and medical fields. The Spinco Division will retain headquarters and manufacturing facilities at the Belmont, Calif. plant.

• **Wilmot Castle Company,** manufacturer of hospital sterilizers of all types, medical-dental lights and sterilizers, bacteriological equipment and major surgical operating lights, announces removal of its plant and offices from its present plant to new facilities at **1777 E. Henrietta Rd., Rochester 18, N.Y.** Greatly increased production facilities, scientific testing laboratories and modern facilities for employes are some of the features of the new building which is 45 per cent larger than the old factory and has modern technical, engineering and production advancements.

Johnson Service Company, 507 E. Michigan St., Milwaukee 2, Wis., manufacturer of automatic temperature control systems, announces the opening of new branch offices at Akron, Ohio; Mobile, Ala.; New Haven, Conn.; Sacramento, Calif.; Springfield, Mass.; Tampa, Fla.; Wilkes-Barre, Pa., and Youngstown, Ohio.

The Michaels Art Bronze Co., Inc., Erlanger, Ky., manufacturer of ferrous and nonferrous metal products, including metal letters, display cases, bronze tablets and markers, parking meters and other products, announces the opening of new offices and factory on the Dixie Highway, eight miles southwest of Cincinnati, Ohio. The new facilities enable the company to increase production and expand its activities. The plant was formerly in **Covington, Ky.**

Ward, Dreshman & Reinhardt, Inc., is the new corporate name of the fund-raising firm located at **30 Rockefeller Plaza, New York 20,** formerly known as **Ward, Wells, Dreshman & Reinhardt.** The expanded firm will enter upon a larger field of service backed by 50 years of experience in fund-raising efforts for hospital, religious, educational and philanthropic institutions.

PRODU

Inde

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The Colson Corporation

792 Ice Making Machines
Carrier Corp.

793 Cubicle Curtains
Webb Mfg. Co.

794 Plastic Louvers
Kurt Versen Co.

795 Super Westwax
West Disinfecting Co.

796 Copying Machine
Minnesota Mining & Mfg. Co.

797 Redesigned Nightingale
American Hospital Supply Corp.

798 Ambulance Bodies
Meteor Motor Car Co.

799 Lincoln Jet
Lincoln-Schlueter Floor Machinery

800 Mobil-Meal Conveyor
Mansfield Aircraft Products Co.

801 Radio Osteometer
Orthopedic Equipment Co.

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May, 1955

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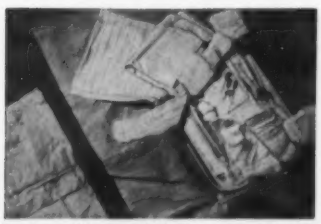
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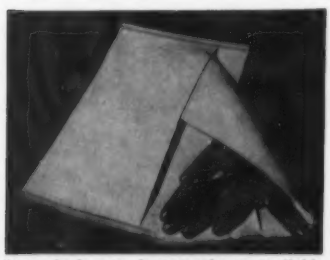
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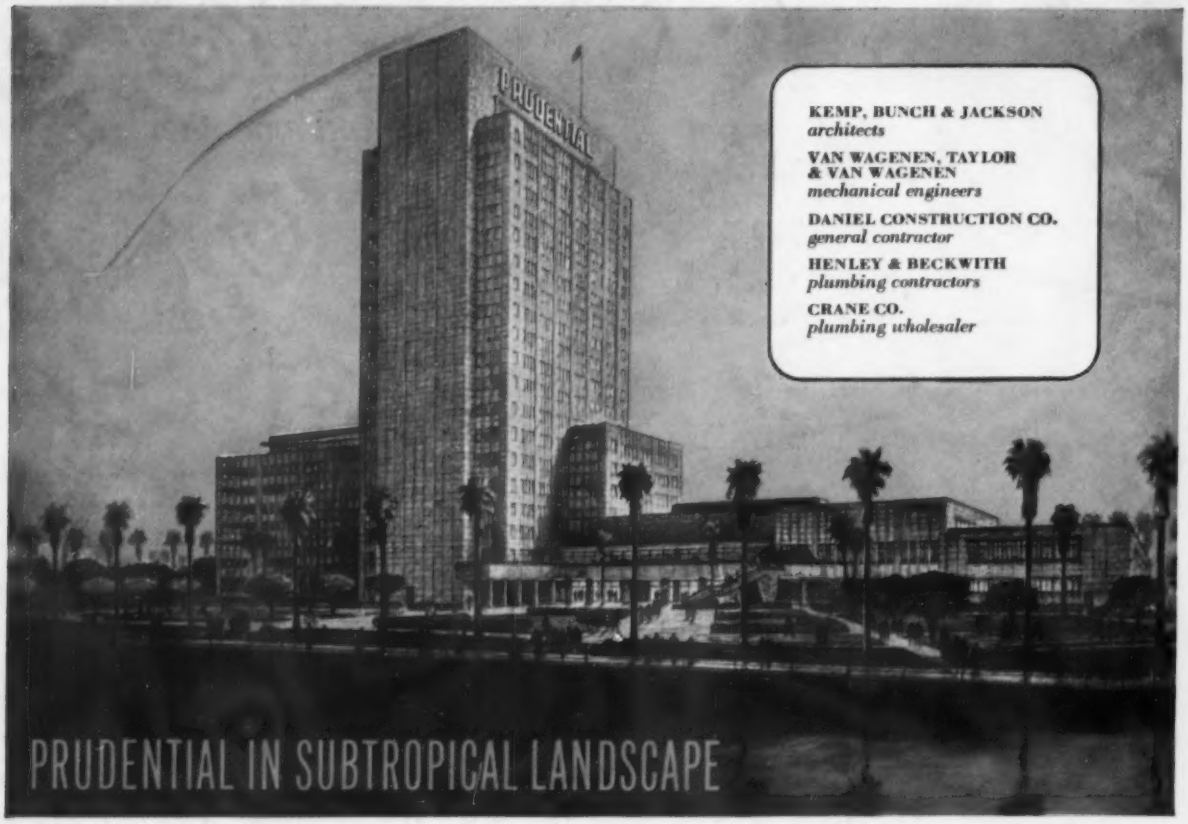


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